CITY UNIVERSITY, LONDON

School of Social Sciences

Department of Psychology

A Scientific Study of Strengths and Virtues

A contribution to the field of Positive Psychology

Stavros Markatselis; BA (Hons); MSc.

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Advanced Specialist Case Study

Advanced Specialist Process Report

City, University of London
Northampton Square
London
EC1V 0HB
United Kingdom

T +44 (0)20 7040 5060

THE FOLLOWING PARTS OF THIS THESIS HAVE BEEN REDACTED FOR DATA PROTECTION REASONS:

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v. Declaration

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vi. Abstract

Objectives: Positive psychology philosophy underpinned the rationale of the current study. The aim of the research was to examine factors that are considered to cultivate human strength. It was hypothesised that hope and perceived social support will be associated with and will predict participants' subjective life satisfaction. Secondary objectives were to investigate how well the data obtained supported the theoretical models upon which the questionnaires were based.

Method: This quantitative study utilised a cross-sectional design. One hundred and fourteen participants from the community aged between 21 to 65 years, completed questionnaires regarding perceived social support (Medical Outcomes Study Social Support Survey), hope (Adult State Hope and the Adult Trait Hope Scales), and subjective life satisfaction (The Satisfaction With Life Scale). Participants were approached in shopping areas in London and Surrey. Internet methods of recruiting participants provided supplementary data.

Results: The main hypotheses were partly supported by the results. All dimensions of hope and social support were found to relate significantly with subjective life satisfaction. Agency, which refers to the individual's perceived capacity to initiate and sustain actions towards desired goals, emerged as the most significant predictor of subjective life satisfaction. Global Perceived social support was found to be a stronger predictor of subjective life satisfaction than global hope. The co-habiting and married groups perceived that they have significantly more tangible and affectionate support when they needed it than singles. Cohabitees' reported significantly more overall support than singles. Principal Components Analyses of the Medical Outcomes Study Social Support Survey which was used to assess perceived social support and the dispositional and situational hope measures supported the theoretical frameworks the questionnaires were based on.

Conclusions: The study confirms existing results and supports the idea that a person could increase subjective life satisfaction when is motivated to initiate and sustain movement toward goals. Results also points out to the direction of researching family life and social relationships in understanding subjective life satisfaction. Data provided evidence that hope and social support are multidimensional concepts. The implications of these findings for theory, measurement and clinical practice are discussed.

OVERVIEW

The purpose of this overview is to integrate various aspects of my work contained within this portfolio namely, critical literature review, research thesis and case work, in order to reflect on my professional growth during the course in counselling psychology. I chose the concept of hope to be the link between the different kinds of work which I present here. This is because my life experiences have taught me that hope is an essential ingredient of good life. I always tried to remain hopeful even in the most difficult circumstances. This helped me to keep motivated, to overcome obstacles and to attain desirable goals. I adhere to the notion that people aspire to cultivate what is best within themselves in order to live meaningful and fulfilling lives. That is why I wanted to design a research study that aimed to contribute to the field of Positive Psychology. The field of Positive Psychology is devoted to the empirical scrutiny of constructs that are considered to cultivate human strength. The Professional Doctorate in Counselling Psychology gave me the opportunity to empirically scrutinize positive constructs such as hope. I believe that researching hope can enable us to establish the specific ways which can lead us not only to maintain our hopefulness, but to increase it further in order to enhance our happiness, life satisfaction and to enjoy our lives to the maximum. Indeed, my research thesis provides findings consistent with the idea that hope can help us increase our subjective life satisfaction.

The Professional Doctorate in Counselling Psychology was a valuable experience that led me to increase my awareness of how I can maintain and increase my clients' hopefulness and mine. The theoretical knowledge that I obtained through exposure to a variety of psychological approaches, influenced not only my professional practice, but had an impact on my self. Specifically, during my clinical work, the process of identifying my clients' negative thoughts and unhelpful beliefs, whilst practising the cognitive behavioural model, led me to begin being more aware of my own thought processes. On various occasions, I caught myself experiencing negative thoughts. I became more mindful of the

negative impact that they had on my mood and feelings. Similar to my therapeutic work with clients, I began evaluating my thoughts. This process enabled me to identify my own unhelpful beliefs. I began to challenge my beliefs because I wanted to change aspects of myself that were preventing me from reaching my potential. This process of self-evaluation and intentional effort towards personal change, led me to improve myself personally and subsequently professionally.

The course enabled me to move towards a professional position as a critical and reflective scientist-practitioner. This portfolio, I feel contributed vastly to this. This was also accomplished through engaging in tasks, such as clinical work, supervision and through attending academic teaching at the university. Writing the critical literature review helped me to advance my critical thinking skills as its purpose was to critically review, synthesize, and analyze the scientific literature. This ensured that I managed to evaluate evidence carefully, before reaching a certain conclusion. For example, before I completed my critical literature review, I had always assumed that when our levels of hopelessness decrease, this will instantly stimulate increases in our levels of hopefulness. However, after reviewing the psychological literature, I realised that this is not the case. I became aware that hopelessness and hopefulness are different constructs and therefore are influenced by different factors. This idea became the foundation of my research thesis. I asked myself the question 'If alleviating suffering (i.e. hopelessness) does not necessarily lead us to increase our happiness and well-being, then which factors can help us to accomplish this'? I decided to research hope and social support as many psychologists consider that these concepts help us cope with suffering and adversity. Yet there is still no published study which has investigated whether these variables lead us to evaluate our lives in a positive manner.

My critical thinking style also helped me with the interpretation, analysis, and evaluation of my research findings as well as those of others. Moreover,

whilst on the course, I progressively began to analyse my thoughts before verbalising them. I became more reflective in my day-to-day interactions. I am more aware of my impact, not only on the therapeutic process with clients, but also in my day-to-day interactions. I learned to set realistic goals by recognising my personal strengths and limitations and also those of my clients.

The course enabled me to enhance my coping skills and by doing so to maintain my hopefulness even during difficult moments. I learned to be more aware of the impact that a given situation is having upon me. I learned to monitor and to adjust my personal expectations when necessary. As the training progressed, I became increasingly aware that I was developing both personally and professionally. I began to feel more capable of dealing with personal difficulties, by identifying what they are.

Focusing on specific interests in my academic work and therapeutic practice (i.e. specific models of the cognitive behavioural approach) provided me with a sense of accomplishment, satisfaction and personal growth over time. This positively influenced my levels of hopefulness by fostering the perception that I chose a profession that suits me. I had the opportunity to carry out case work, such as the advanced case study documented in this portfolio, in order to demonstrate competence in my ability to integrate psychological theory and research with clinical practice. Through this process I managed to advance my theory-practice links. The client study included in this portfolio, illustrates various cognitive-behavioural strategies aimed at increasing the hopefulness, confidence and self-esteem of a woman with depression and anxiety.

Hope theory highlights, that those individuals who have the motivation and also contemplate the specific pathways to get the things they desire in life, are likely to be hopeful. I learned by completing this course that it is unproductive to procrastinate. I realised as the training progressed that it is adaptive to try to find ways to solve my problems. As part of this process, I found myself trying to

consider various ways of coping with the demands. I engaged in less avoidance coping and placed particular effort on accessing appropriate support. My motivation to accomplish my goals and my intentional effort to seek ways of solving my problems enabled me to achieve academic, work-related and personal goals, which I had previously appraised as unmanageable. I remained hopeful throughout the training and this helped me to meet the academic and clinical components of the course effectively.

One of the things that I enjoyed most about completing training is that it enhanced my knowledge. The course has provided me with the opportunity to learn about various therapeutic approaches such as cognitive-behavioural therapy, systemic therapy, the psychodynamic approaches, solution focused therapy etc. What I particularly enjoyed, was the opportunity that I had to practice the theoretical knowledge that I had been introduced to in tutorials at the university, with clients at my clinical placements and to write case work such as the advanced client study which is presented in this portfolio. The course structure is in congruence with my preferred learning style, which is pragmatic, as I like to practice what I learn. By practising the theory, I developed a range of clinical skills and enhanced my theory practice-links.

As the course progressed, I found myself feeling less de-skilled. I began to have a greater trust in my clients' judgements and in their capacity to change. I progressively became more relaxed whilst I was practicing and whilst in the learning group. All of the above became positive experiences that I brought to the learning group. At the beginning of the training, although we were taught 'how to be' rather than 'what to do' with the client and to trust the client's capacity to help themselves, I noticed myself to be more prone to the idea of being 'in charge' of the therapeutic sessions. As I progressively gained more experience, I came to recognise that I needed to be more flexible in my therapeutic practice. I began to recognise that not everything is as black and white as I considered them to be

when I started training. I began to consider my therapeutic work with clients as collaborative, rather than as an attempt to 'do something to the client'.

The purpose of the doctoral research thesis contained in this portfolio, is to present a literature review, research findings and discussion of these results in order to demonstrate competence in conducting psychological research. The thesis aims to make a unique contribution to the field of positive psychology. Completing the doctoral research was a challenging but intellectually stimulating experience. The hardest task of my thesis was recruiting participants. Don Rawson, my research supervisor, was supportive and generous with his time and guidance. His constructive feedback had a positive impact on my work. Don also gave me confidence and ensured I stayed hopeful and motivated in the process of recruitment. As a consequence, I obtained the desired number of participants for my study. Completing the thesis enabled me to expand my skills in different research stages, that is, from critically reviewing the literature, to data analysis which advanced my statistical knowledge. I also improved my oral and presentation skills by presenting my research progress at the university. I set a work schedule to which I tried to adhere. Adhering to the timetable was at times a great challenge. However, having it helped me remain aware of the progress I was making. I was mindful not to ignore or put off requirements that were due. I noticed that my hope increased as I progressively met the targets of my timetable. The schedule fostered my perception that I could achieve the goals that I set for myself.

The discussion of my thesis and my literature review, highlight the importance of supportive relationships in promoting and maintaining hopefulness and well-being. I was fortunate to work with colleagues, both in the university and at my clinical placements, who were stimulating and supportive. This made my work more interesting particularly as in several instances I was physically and emotionally tired, due to the constant pressure and the long working hours. As the

training progressed, I increasingly learned to balance my work and my personal life which also helped me to complete this portfolio and the other academic and clinical assessments. I found it relaxing and self-rewarding to engage in external activities to my work as a counselling psychology trainee such as: playing basketball, swimming, and listening to music.

As the course progressed, I began expressing my opinion without fear, but with curiosity and active engagement. I learned to be more diplomatic. I learned to be more open-minded and less judgmental. I adopted a structured and disciplined approach to learning. I became more autonomous and more responsible both personally and professionally. I became less fearful of feeling de-skilled. I am willing to continue learning so that I can improve my existing skills. I have come to recognise that, as much as I have already learned, there will always be something further to learn.

In summary, this overview aimed to illustrate how the concept of hope links the various types of the work presented within this portfolio with subsequent implications to my personal and professional growth. I feel that the Professional Doctorate in Counselling Psychology has given me the opportunity to improve myself personally and professionally in various ways. The course prepared me well for the challenges that I will soon encounter in the real world as a qualified psychologist. Embarking on it, was undoubtedly one of the best decisions I made so far in my life and truly I enjoyed every bit of it.

CRITICAL LITERATURE REVIEW

What is the role of hopelessness in depression?

Stavros Markatselis

What is the role of hopelessness in depression?
A review and critique of the literature

Overview

The scope of this review addresses issues associated with a depressogenic attributional style, the tendency to attribute negative life events to internal, global and stable factors. This cognitive style is a key component of the hopelessness theory of depression. Due to the brevity of this discussion, concepts associated with attributional theory, such as hardiness and locus of control, are not covered because they are not directly relevant to the question addressed by this literature review. This review is relevant to the practice of counselling psychology because it can increase awareness of the various competing and complementary approaches proposed to explain vulnerability and the aetiology of depression, as well as the factors that maintain this disorder. The variables that are proposed to be associated with recovery from depression are also discussed. Needles and Abramson's (1990) model of recovery from depression is concluded to be a fruitful area for future research. This should be of interest to Counselling Psychologists because it has the potential to shed light upon the factors implicated in the process of recovery from this disorder and consequently helps the development of more effective interventions to address depressed clients' needs.

During the 1970's psychologists began to recognise the limitations of psychoanalytic and behavioural models of psychological disorders and so shifted the focus towards the development of theories with a more cognitive foundation. Early behavioural theorists founded their explanations for the development of depression upon the concept of positive and negative reinforcement. Their ideas were based on the rationale that depressed people received fewer rewards and more punishments than the non-depressed. Lewinsohn's (1974) theoretical assumption, for example, led him to assert that "*depression amounts to the emission of no behaviour, whereas not being depressed means emitting behaviour. Getting reinforced for not responding leads to not emitting behaviour and therefore to depression*" (In Price, Tryon & Raps, 1978 p.113). Equally, Skinner (1974) postulated that *"when reinforcement is no longer forthcoming, behaviour undergoes extinction…a person is then said to suffer a loss of confidence, certainty, or sense of power. His feelings range from a lack of interest through disappointment, discouragement, and a sense of impotence to a possibly deep depression"* (p.181).

Behavioural explanations did not succeed in elucidating the multiform features of depressive symptomatology and especially the role of cognitions. Behavioural practitioners struggled with questions like how best to conceptualise their clients' cognitions and how to fit such cognitions into the complex reciprocal interrelationships with peoples' feelings, behaviour, and resultant consequences, as well as with physiological and socio-cultural processes (Teasdale 1988). The

dissatisfaction with both the empirical and the theoretical bases of a strictly behavioural approach became apparent and opened the way for cognitive theorists, in particular Aaron Beck and Albert Ellis, who later combined behavioural ideas with cognitive principles. Behavioural therapy aims to change actions that are harmful or unhelpful, by using strategies such as reinforcement techniques. Cognitive therapy focuses on our thoughts, which include our ideas, mental images, beliefs and attitudes. The aim is to alter ways of thinking which create negative emotions such as guilt or anger.

One of the main founders of the integrated cognitive behavioural approach was Beck (1979) who observed that the way in which his clients perceived situations influenced how they felt emotionally. Beck initially focused on depression and proposed a list of "errors" in thinking that he suggested could cause or maintain depression. These included *arbitrary inference*, *selective abstraction*, *over-generalization*, *magnification* (of negatives) and *minimization* (of positives). Cognitive therapy aims to identify and change "distorted" or "unrealistic" ways of thinking, and therefore to influence emotion and behaviour.

Ellis (1973) also contributed to the growth of the integrated cognitive behavioural approach with his influential writings on the development of Rational Emotive therapy (RET). Ellis argued that human beings are born with the dual potential for both healthy and unhealthy thought processes. He called the healthy process rational thinking and the unhealthy irrational. According to Ellis rational thinking

means objectively seeing things as they really are, whereas irrational thinking distorts reality by misinterpreting things that happen. Therefore according to his theory rational thinking is consistent with facts, whilst irrational thinking is inconsistent with or unsupported by facts. Ellis supported that thoughts precede emotion. He argued that emotions have nothing to do with actual events but are caused by the meaning we attach to a certain situation. When the thought is irrational, then according to Ellis the emotion could be exaggerated and therefore unhealthy. He argued that the emotions we feel are caused by the thoughts we have and we can change our emotions only by changing our thoughts. This approach however was criticised for neglecting to explain how environmental influences contribute to the development and maintenance of irrational thoughts (see Eschenroeder, 1982).

In 1974 Beck, Weissman, Lester and Trexler, developed the Beck Hopelessness Scale (BHS), a 20-item assessment measure designed to assess negative expectations about the future. Beck originally developed this scale in order to predict who would commit suicide and who would not. A principal components analysis of the BHS for suicide attempters revealed three components: (1) feelings about the future, (2) loss of motivation, and (3) future expectations. However, at that time the concept Hopelessness lacked of a clearly articulated theory.

Whilst studying escape learning in an investigation based on the Pavlovian conditioning theory, Seligman and Hiroto (1975) demonstrated that dogs that were forced to stay in a box where they received inescapable shocks, gave up their attempts to escape in a short space of time. Moreover, sixty five per cent of the dogs did not try to escape the next day when the box was modified so they could easily escape. When the study was re-conducted with human subjects, a group who received inescapable aversive tone showed significantly weaker tone escape performance as compared to a control and an escapable pre-treated group. Additionally, a group pre-treated with four insoluble discrimination problems performed weaker at solving later anagrams relative to a control and solvable pre-treated group (Seligman 1975).

These experiments led to the development of the learned helplessness model, which was proposed to account for emotional, cognitive and motivational deficits that could result when individuals perceived that important life events were beyond their control (Seligman 1975). Consequently Seligman & Hiroto (1975) postulated that experience with prior uncontrollable outcomes and the consequent expectation that future events would be uncontrollable, could perhaps be linked to the development of depression in people. In the following years, the model received enormous interest amongst social psychologists working with experimental methodology. However, very soon researchers demonstrated the limitations of the model by beginning to question its inability to explain why

many individuals in helpless circumstances do not become depressed and why the theory does not elucidate the *guilt, shame, and self-blame* that often accompanies depression. How can you feel helpless for example, without any ability to control what happens and at the same time, feel at fault and guilty about what happened?

Acknowledging that the original model did not appear to be adequately flexible to account for the various forms of depression (Coyne & Gotlib 1983) and in response to the various criticisms of their work, (Abramson, Seligman, & Teasdale, 1978) reformulated the original version. A further attributional dimension was incorporated into the theory and according to the theoretical progression it was presumed that individuals inclined to depression would attribute negative outcomes to internal ('it's my fault'), global ('this affects everything'), stable ('things can't change'), factors.

Although the theory was linked to depression, it was not explicitly presented as a clearly articulated theory of depression. Instead it presented an attributional account of helplessness and only briefly discussed its implications for depression (Abramson, Alloy & Metalsky, 1989). There were further problems. Since both the hopeless self-blamer and the hopeful self-helper see the causes of their behaviour and feelings as being internal, internal causes may lead to optimism as well as pessimism. Additionally, new questions arose, such as "how do we know that the feelings of helplessness or hopelessness precede and cause depression, rather than just being a natural part of feeling depressed?" Although

the theory was not a comprehensive explanation of the aetiology of depression, it highlighted the role of cognition in depression in addition to the theory's more behavioural origins. It created the foundations for further investigation of this phenomenon and provided a basis for the development of the hopelessness theory of depression.

Influenced by the critics of the reformulated theory, Abramson et al. (1989) reflected upon some of the difficulties and modified the 'helplessness' theory into the 'hopelessness' theory. By building on the structural logic of Abramson's et al. (1978) reformulated theory and with the central conception to provide the psychological literature with a more detailed theory that conceptualised a cognitive style which may cause and/or sustain depression. They proposed that a pessimistic attributional style (the tendency to attribute negative life events to global and stable causes) interacts with negative life events to stimulate the occurrence of hopelessness and consequently depression. Hopelessness was viewed as playing a central role in the development of depression and was considered as a proximal and sufficient cause of depression, so that any increases in hopelessness will stimulate increases in depression.

Hopelessness was defined as "*an expectation that highly desired outcomes will not occur or that highly aversive outcomes will occur coupled with an expectation that no response in one's repertoire will change the likelihood of occurrence of these outcomes*" (Abramson et al. 1989 p.359). In contrast with the 'Helplessness' model, the 'Hopelessness' theory demonstrates a highly detailed

causal format, which clearly specifies a sequence of events in a causal chain towards hopelessness depression. Negative life events according to this casual chain operate as environmental stimuli for individuals to become hopeless if they infer (a) stable and global attributions for the cause of the event, and/or (b) negative characteristics about the self according to the event, and/or (c) negative consequences because of the event.

Consequently Abramson et al. (1989) hypothesised that hopelessness depression should be followed by a certain set of symptoms, including two primary ones, retarded initiation of voluntary responses, (a motivational symptom) and sad affect (an emotional symptom). Additionally, a number of secondary symptoms including lack of energy, sleep disturbance, difficulty in concentration, mood-exacerbated negative cognitions, suicidal ideation, apathy and psychomotor-retardation were also proposed.

In the following years the hopelessness theory received considerable attention and research findings have supported certain of its elements. Alloy, Lipman and Abramson (1992) for example, illustrated that the tendency to attribute negative life events to internal stable and global causes increased vulnerability to depression. This finding has implications for clinical practitioners such as Counselling Psychologists because it confirms that this depressogenic attributional style could be responsible for predisposing their clients to become hopeless and thereby depressed. The counselling practitioner's aim could therefore be to encourage clients to break away from the tendency to attribute

negative life events to internal, global and stable causes, in order to prevent them from becoming increasingly hopeless and therefore increasingly depressed.

Alloy and his colleagues discovered that, when interviewed about the past two years of their lives individuals who scored highest on the internal, global and stable dimensions for negative life events, reported experiencing higher rates and a larger number of episodes of major depressive disorder than those who scored lower in the internal, global, and stable dimensions for negative life events. It should be noted however, that participants responded to the interviews retrospectively, which might have limited the accuracy of the recall of events and also potentially led to recall bias.

Another aspect of the hopelessness theory as proposed by Abramson et al. (1989) was examined by Kapci (1998). He investigated whether subjects who both draw negative inferences about themselves from the occurrence of negative life events, and who experience a large number of negative life events, are more likely to be depressed than are subjects who do not exhibit this tendency (to draw negative inferences about themselves from the occurrence of negative life events), or who do not experience a large number of negative life events. Kapci (1998) examined seventy individuals and applied a prospective design as he administered the Beck Depression Inventory and the hopelessness scale at session one. He also gave participants the Life Events Scale (Dohrenwend, Krasnoff, Askenasy & Dohrenwend, 1978) which he asked them to complete every night for three months to report what had been happening to them. Kapci followed Abramson et

als' (1989) proposal that a three month interval is the suggested time period for the development of hopelessness. In session two, which took place three months later, participants were asked to return the Life Events Scale and to fill in the BDI and the hopelessness scale. A total of 34 dysphoric and 36 non-depressed undergraduate students participated.

Kapci's findings were consistent with the hypothesis. Participants who felt that their self-worth decreased after the occurrence of negative life events, in conjunction with the experience of a large number of negative life events, were more likely to experience high levels of depression within three months. These findings have implications for clinical practice in developing interventions to combat depression. They highlight that hopeless clients could benefit from clinical interventions aimed at modifying the habitual cognitive style for negative events, which has been found to predispose them to draw negative inferences about themselves.

Kapci's findings also provide partial support for a theory proposed by Beck (1967) known as the *cognitive triad of depression*. Specifically, Kapci's results support Beck's suggestion that a negative view of self is a characteristic of depression. Beck's *cognitive triad* also suggests that a negative view of the world and the future are also features of depression. Kapci's study however did not assess these additional two aspects of Beck's theory. The cognitive triad of depression is therefore, according to Beck, a negative self-perception whereby people see themselves as inadequate, deprived and worthless. They experience the

world as negative and demanding. They learn self-defeating cognitive styles, to expect failure and punishment and for it to continue for a long time.

Kapci assessed participants over a long period of time. The prospective nature of the design should lead us to expect improvement in the accuracy of the recall of events and decreased recall bias. A methodological limitation arises however, if we consider that requesting participants to respond to a questionnaire every night for three months may be too long for them, increasing the possibility of a decrease in their motivation. This fatigue effect may subsequently result in poor respondent co-operation. We cannot therefore exclude the possibility that some participants filled in the questionnaire retrospectively for some days, a process which could lead to recall bias.

In a cross-sectional prospective study Kanner, Coyne, Schaefer and Lazarus (1981) revealed that daily hassles can be even more predictive of psychological symptoms than are major life events. The researchers found that hassles scores were strongly related to both affective distress and psychological symptoms. Kernis, et al. (1998) investigated the role of hassles and attributional style in the levels of depression. The researchers administered the 117 item 'hassles scale' (Kanner, Coyne, Schaefer & Lazarus, 1981) to an undergraduate sample in order to measure depressive symptoms at two time periods. A period of approximately four weeks separated the initial and the final administration of the questionnaires. The findings indicated that the tendency to attribute negative life events to stable

and global factors was related to a greater number of depressive symptoms at final administration among individuals who reported substantial daily hassles. This study however had two methodological limitations. Firstly, participants were students who received extra credits for their participation. The sample therefore was biased towards a specific group of people, limiting the generalisibility of the results to a wider population. Secondly, the sample was biased in favour of women as only fourteen participants were male and eighty-four were female.

A review of the literature suggests that there has been sufficient empirical research into the role that causal attributions for negative life events have in leading us to feel hopeless and depressed, as indicated by the hopelessness theory. However, the role of positive life events in depression and whether causal attributions for positive events may be a significant factor in the aetiology of depression has received relatively little attention.

Early in the nineteen seventies, Lewinsohn & Libet (1972) investigated the role of pleasant life events in depression. They placed college undergraduates into three groups and each group consisted of ten people; five males and five females. They then constructed a depressed group, a psychiatric control and a normal control, according to participants mean scores on the Byrne Scale (see Byrne, 1981) and the Minnesota Multiphasic Personality Inventory (MMPI) (Hartley & Allen, 1962). Lewinsohn and Libet (1972) asked participants to respond to the Feelings and Concerns checklist and on the basis of their scores, a dysphoric

group, a material burden, a loneliness, and a guilt group were constructed. Results demonstrated a significant relationship between the number of "pleasant activities" and concurrent mood in depressed and non-depressed groups which led the researchers to conclude that there is an association between the rate of positive reinforcement and intensity of depression. Although the researchers were careful to consider only correlation coefficients greater than .30 which would be significant at the .01 level, a correlation cannot prove causality in the relationship between the variables examined. Furthermore, an additional methodological limitation of the study is that the sample consisted of students who were paid for their participation.

Seligman, Abramson, Semmel and von Baeyer (1979) found that low scores on internality and stability for pleasant outcomes on the Attributional Style Questionnaire correlated with high scores on the BDI, but the relationship was weaker than that found for attributional style for negative life events. The authors reasoned that the role of attributions for positive events might not be as direct as that of attributions for negative events in the onset of depression.

Needles & Abramson (1990) pointed out that although it is reasonable and important to study the effects of positive events on the course of depression, they are quite different in scope from the kinds of major negative life events investigated in many studies of onset of depression (e.g. death of a friend, loss of a job). Needles and Abramson (1990) viewed episodic events and ongoing

situations however as important elements which contribute to levels of hopelessness and depression.

Frith & Brewin, (1982) investigated the role of casual attributions in the process of recovery from depression in an in-patient population. They tested only twelve individuals, eight females and four males who reached a score of fourteen on the Beck Depression Inventory. Participants were interviewed within five days of commencement of the course of antidepressants, therefore before medication become effective. They initially completed the life events inventory, responding to events experienced over the past two years, as well as completing the Beck Depression Inventory and the Attributional Style Questionnaire. They discovered that relative to the sample of non-depressed patients, the moderately depressed individuals attributed their life-events and symptoms to causes which were significantly more global and more uncontrollable, but not significantly more internal or stable than those of controls. The methodology of this study however did not utilise a standardised measurement for all participants, as the eight depressed women who were all receiving antidepressant medication were re-assessed after six weeks, in contrast with the four males who were not re-assessed and of whom only one was receiving treatment. Considering also the small number of participants which limits the generalisability of the results, it was evident that further investigation was needed to verify the representativeness of the results.

Needles & Abramson (1990) proposed a model of recovery from depression with important implications for the clinical practitioner. The proposed model is broadly based on the hopelessness theory of depression (Alloy et al. 1988; Abramson et al. 1989). The hopelessness theory supports that an internal, global and stable attributional style interacts with negative life events to predict onset of hopelessness and thereby depression. The recovery model in contrast proposes that the tendency to attribute positive life events to global and stable causes, interacts with the experience of episodic, ongoing positive events to predict offset of hopelessness and thereby recovery from depression.

Needles & Abramson (1990) requested nine hundred and seventy two students at the University of Wisconsin to complete the Beck Depression Inventory. Seventy-two students who scored sixteen or above in the inventory, suggesting moderate to severe depression, were included in the study. Using a six-week prospective design, they then requested their participants at week one to respond to the Attributional Style Questionnaire, the BDI, the Hopelessness scale, as well as the Positive Life Events questionnaire and the Negative Life Events questionnaire. Participants who scored below ten in the BDI at time one were excluded from the study. The administration of the questionnaires continued once per week for the next five weeks. Results provided support for the model of recovery and sustained that the occurrence of positive life events may initiate a process leading to recovery. Thus, depressives who exhibited a tendency to attribute positive life events to global, stable causes, were more likely to become

hopeful and less depressed when confronted with a positive event (Needles, & Abramson 1990).

In 1996, Johnson, Crofton and Feinstein were the first to test the Needles and Abramson's model (1990) in an in-patient population. They permitted individuals to participate in the study only if they met the following criteria: (1) Diagnosis of major depressive disorder and/or a baseline score of 16 or higher on the BDI and (2) a non-zero baseline response to BDI 'item 2' indicating the presence of Hopelessness, and/or a baseline score of 16 or higher on the Beck Hopelessness Scale. Of the final sample comprising thirty two participants; sixteen male and sixteen female; twenty nine of them reported receiving anti-depressant medication prior to and during their current hospitalisation. The Attributional Style Questionnaire was used to assess participants' attributional style, the BDI to assess depression, the Hopelessness scale assessed Hopelessness, the Dysfunctional attitudes scale assessed dysfunctional thoughts, and the revised Hassles and Uplifts scale was used to assess life events. The measures were first administered at forty-eight hours after their admission and readministered at five, ten and fifteen days.

Johnson et als' (1996) findings indicated that those depressed individuals who presented the enhancing attributional style (the tendency to attribute positive life events to global, and stable causes) and who experienced a large number of positive life events, were more likely than those who did not, to become more

hopeful and thereby less depressed. The authors however noted that it was the combined main effects of a stable, global, attributional style for positive life events, which predicted decreases in hopelessness. Neither a stable or global attributional style for positive events interacted with positive life events as hypothesised, to predict a reduction in hopelessness. Although patients reported relatively high levels of positive events, decreases in hopelessness and decreases in depressive symptom levels; this was not inconsistent with the idea that this may have occurred due to the effect of antidepressant medication, which was not controlled for in the study. Despite this serious methodological limitation, which highlighted the need for further investigation, these findings were of interest to clinical practitioners because they indicated that causal attributions may play an important role in the process of recovery from depression amongst in-patients.

Johnson, Han, Douglas, Johannet, and Russell, (1998) re-tested the model in fifty-two depressed psychiatric in-patients. This time however, the investigators were careful to account for the effects of anti-depressant treatment. Within seventy two hours of admission participants who met the exclusion and inclusion criteria (the same criteria as the 1996 study) were administered the ASQ, the BDI, the Hopelessness scale, the Dysfunctional Attitudes scale and the revised Hassles and Uplifts scale. Measures were readministered at twelve and twenty four days after admission. Their findings suggested that in-patients who underwent a change in medication status between admission and discharge did not experience greater or smaller decreases in depressive symptoms than those whose

medication status did not change. Furthermore, an internal, stable, global attributional style for positive events, assessed before any medication-related improvement in depressive symptoms could take place, predicted decreases in hopelessness. Johnson et als' (1998) findings differed from Needle and Abramson's model of recovery from depression. Needles and Abramson (1990) proposed that a global and stable attributional style interacts with positive life events to predict offset of hopelessness and thereby recovery from depression. Johnson et als' (1998) findings however indicated that it was an internal, global and stable attributional style for positive life events that predicted decreases in hopelessness. Global and stable attributions alone failed to produce the same effect.

Johnson et als' (1998) findings diverge from those of Needles and Abramson's. Needles and Abramson reported that a stable and global attributional style for positive events interacts with positive events to predict decreases in hopelessness. Johnson et als' findings however, suggested that an internal, stable, global attributional style for positive events predicted decreases in hopelessness independently of life events. These findings suggest that independently of the experience of positive life events, depressed individuals who attribute positive life events to internal-global-stable causes are more likely to be less hopeless and less depressed than individuals who do not have this attributional style.

A study by Johnson et al. (2007) provides further evidence which supports the idea that positive attributional style predicts recovery from depression. The experimenters used a longitudinal design to examine whether processing of emotional stimuli predicts both symptomatic improvement and recovery from major depression. Their procedure involved presenting their depressed participants with a combined list of happy and sad words and then asking them to recall these words a few minutes later. Two hundred and sixty days later respondents were administered a depression inventory. Results suggested that those depressed participants who had recalled a higher proportion of positive words at time one, exhibited greater symptomatic improvement at follow up. One serious methodological limitation was that respondents were presented with more happy than sad words. It is possible that this design influenced the results, since participants had more opportunities to recall more positive than negative words. The researchers reported however that in another study they obtained comparable results with a larger combined list of negative words.

Another methodological issue, relevant not only for this study but for any research on depression, is that some researchers may argue, as Tennen, Hall and Affleck (1995) did, that depressed participants should be screened for other psychopathological states such as anxiety and also be compared with non-pathological control groups. This procedure can help researchers to examine whether results can be clearly attributable to depression and whether a significant difference exists between a non-depressed and a depressed group. Although the

consequences of neglecting to do this can be potentially serious to any study that is designed to assess depression. It is also important to recognise that the cost of adhering to these recommendations demands more time, resources and possibly more investigators. Utilising non-pathological control groups moreover does not necessarily enable researchers to establish that the difference can be attributable to depression.

A serious conceptual and methodological limitation of studies which have so far tested Needle's and Abramson's model of recovery from depression, is that they have not utilised a hope measure to assess hopefulness, instead assuming that decreased hopelessness is equivalent to increased hopefulness. A review of the literature suggests that the way hope is conceptualised, serves functions which are different from the concept of hopelessness. Hope is considered to have the opposite effect of hopelessness, in a sense that whereas hopelessness is defined as "*an expectation that highly desired outcomes will not occur or that highly aversive outcomes will occur coupled with an expectation that no response in one's repertoire will change the likelihood of occurrence of these outcome"* (Abramson, et al. 1989 (p. 359). On the other hand, the definition of hope which has received most scholarly attention by experimental psychologists is that proposed by Snyder et al. (1991), which conceptualises hope as *'a cognitive style that can serve as a motivational factor to help initiate and sustain action toward goals'* (p. 571). This theory views hope as a cognitive set based upon a reciprocally derived sense of successful agency (thoughts associated with goal-directed determination) and

pathways (thoughts about planning ways to meet goals). Research studies have shown that hopelessness has been linked to depression (e.g. Alloy, Limpan, & Abramson, 1992). In contrast hope was found to relate to subjective well-being (e.g. Bailey et al. 2007) and positive activity such as perseverance which could lead to achievement of goals (Peterson, 2000).

The conceptualisations provided above and the evidence obtained from research studies, indicate that hope and hopelessness are two distinct concepts. The question we need to address is whether we can assume, as several previous studies have, that when our levels of hopelessness decrease we become hopeful, since each construct could be influenced by different factors? This question remains unanswered, as all the published studies that have so far tested the model of recovery from depression, (i.e. Johnson et al. 1996; Needles & Abramson 1990) have assumed that decreased hopelessness is equivalent to increased hopefulness. This assumption has prevented experimenters utilising a hope measure to assess hopefulness, despite the fact that it is increased hopefulness not decreased hopelessness that is hypothesised by Needles & Abramson to contribute to recovery from depression. As a result it has not been possible to ascertain whether in the process of recovery from depression, levels of hopelessness and hopefulness are influenced by different factors. We are yet to discover whether life events are stronger predictors of hopefulness rather than hopelessness, or whether the reverse is true. We also do not know whether causal attributions for positive events are predictors of increased hopefulness.

There is a lack of research testing Needle & Abramson's (1990) model of recovery from depression in assessing the role of hope in helping depressed individuals to regain positive mental health. For the purpose of this literature review therefore, attention has been directed towards studies which although not designed to test the model of recovery from depression, nevertheless produced results that could enhance our understanding about the role of hope in depression. One such study was conducted by Elliott, Whitty, Herrick & Hoffman (1991), who amongst other hypotheses, also examined whether hope is inversely related to depression. By utilizing a cross-sectional design, the researchers interviewed forty-five men and twelve women with traumatically acquired spinal cord injuries. A self-report inventory to Diagnose Depression (Zimmerman, et al. 1986) was used to measure depression, the Sickness Impact Profile (Bergner, Bobbitt & Carter, 1981) assessed psychosocial impairment and the Hope Scale (Snyder et al. 1991) measured the components of hope. Their results indicated that hope was negatively correlated with severity of depressive symptoms. Hopefulness and in particular pathways cognitions (thoughts about planning ways to meet goals) was significantly and inversely predictive of depression and impairment overall. The experimenters hypothesised that those participants who had been injured longer and had higher scores on pathways cognitions, were more able to develop effective means of addressing problems that were threatening earlier in the injury, such as problems with social mobility, personal hygiene, and interpersonal relationships. Hence, the cognitive style which predisposed some of their

participants to have thoughts about planning ways to meet their goals was found to be responsible for lessening the severity of their depressive symptoms and overall impairment. Given that correlations cannot be validly used to infer a causal relationship between variables, it is not possible from this study to draw any definitive conclusions as to whether there is a causal relationship between hope and severity of depressive symptoms.

After noting the lack of longitudinal experiments aimed at exploring the effects of hope in depression. Arnau and colleagues (2007) designed a longitudinal study aimed at addressing the question of whether hope has a causal influence on reducing symptoms of depression. The experimenters requested five hundred and twenty two college students to respond to measures of hope and depression at three time intervals, with one month delays between administrations. The predominately Caucasian sample (83.9%) responded to the BDI-II (Beck et al., 1996), the Centre for Epidemiologic Studies Depression Scale (Radloff, 1977), the Depression Anxiety Stress Scale (Lovibond & Lovibond, 1995), and Snyder et als' (1991) Adult Hope Scale. The longitudinal design provided evidence for the potentially causal relationship between hope and severity of depressive symptoms. In particular the data provided evidence that higher levels of hope are associated with decreases in depressive symptoms. Although the study provided support to the idea that hope could be a protective factor against depression, it was found to have only a small effect in reducing the severity of depressive symptoms one month later. The experimenters suggested that variables such as the number of

recent stressors, major life events, coping style and social support could all have direct effects on depression. This might explain why the effects of hope on depression were not large and therefore it is noteworthy that a statistically significant effect was found, even though it was small. Furthermore, the experimenters suggested that the idea that hope can be a resilience factor against depression was highlighted by the result that that severity of depressive symptoms did not have any effect on future levels of hopefulness.

It is of equal importance to consider that the results of this study have implications for Snyder et als' (1991) Hope Theory. Snyder and his colleagues had proposed that both *agency* (thoughts associated with goal-directed determination) and *pathways* (thoughts about planning of ways to meet goals) cognitions are necessary for the activation of hope. However, in this study only *agency* cognitions demonstrated an independent, statistically significant effect on depression. This result raises an important question that could be examined by further research. Do *agency* and *pathways* cognitions play a different role across different psychopathological states?

Arnau et als' (2007) study had a more sound methodological design than the aforementioned cross-sectional research conducted by Elliott et al. (1991). The fact that Arnau et als' (2007) sample was predominately Caucasian and consisted of college students does however limit us from being able to generalise the findings to other samples. It is also important for the study to be replicated in a depressed inpatient sample, before any definitive conclusions can be drawn.

Finally, given that Arnau et als' (2007) study highlighted that hope could be a resilience factor against depression, it is worth noting that hope is a concept that has begun to receive increased attention in the context of positive psychology. The field of positive psychology was proposed to help psychologists develop a science that seeks to understand positive emotion, builds strength and virtue, a science that could provide guideposts to help people pursue happiness (Seligman 2002). Further research on hopefulness within a positive psychology context could increase our understanding of the ways in which hope promotes positive psychological functioning, well-being and life satisfaction.

Summary and implications

This critical literature review aimed to provide a comprehensive account and critique of hopelessness theories and research studies on depression. The role of hope in depression was also examined. This review indicates that studies on depression require further clarification of theoretical constructs and more tightly constructed methodology. Such considerations include; differentiating between depression and other disorders, such as anxiety, utilizing longitudinal designs and non-clinical control groups. Although many of the studies included in this review did not adhere to these recommendations it is important to acknowledge that the costs of adhering to such recommendations could be substantial. For example,

utilising non-pathological control groups in addition to clinical groups demands additional time, resources and possibly more investigators.

This critique highlighted the need for researchers interested in testing Needles & Abramson's model of recovery from depression to include a hope measure to assess hopefulness, rather than assume that decreased hopelessness equates to increased hopefulness. Hopelessness and hopefulness relate to different constructs and in the process of recovery from depression these constructs could be influenced by different variables. The utilisation of both a hope and a hopelessness measure in testing the model of recovery from depression, will allow us to examine whether in the process of recovery from depression, our levels of hopelessness and hopefulness are influenced by different factors. It would be fruitful to examine whether life events are stronger predictors of hopefulness rather than hopelessness or whether the reverse is true. Another avenue for investigation could be to assess whether causal attributions for positive events are predictors of increased hopefulness. Taking into account the aforementioned methodological considerations in addressing research questions such as these, could help us to design studies which can strengthen our understanding of the influence of different variables on the process of recovery from depression. The implications for Counselling Psychology are that by enhancing this understanding, we can design more effective interventions to help our clients recover from this disorder.

Further research and theory development on hopelessness could provide counselling psychologists with useful insights into the kinds of relationships they may possibly encounter in their therapeutic work with clients experiencing hopelessness. This client group is arguably characterized by an overwhelming sense of uncontrollability, helplessness and deficiency in the ability to re-direct their life in a happier and more positive way. It is therefore suggested that counselling psychologists focus upon identifying and restructuring their hopeless clients' beliefs about their progress and recovery from depression. This would help to ensure that the clients are not tainted by negative thoughts that could impede their therapeutic progress. For example, an individual experiencing hopelessness may be making good progress in therapy, but may perceive that he is making no progress or attribute any progress to the therapist's skills, or indeed any other external factor, rather than to him/herself. By being more aware of their client's latent themes of hopelessness**,** counselling psychologists can work with them to help them develop and maintain a more hopeful state of mind about their therapeutic progress and recovery from this disorder.

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Research Study

Hope and Perceived Social Support as related to Subjective Life Satisfaction

A contribution to the field of Positive Psychology

Stavros Markatselis

1.1 Introduction

For the last half century after the Second World War, psychological research has been primarily dedicated to addressing mental illness rather than mental wellness. Theoretical models have been developed mainly to explain how people are 'wrong' and how and why they become ill, rather than how and why they are 'right' and what makes people happy, fulfilled and satisfied with their lives. Psychologists devoted their attention to researching negative constructs that they considered to be harmful to our mental health. They sought to find ways to repair this damage using the Disease/Illness Model of Human Functioning as a framework. As a result we can now measure complicated concepts such as depression and anxiety and have been able to develop psychological interventions to enable sufferers to recover from negative states.

Seligman (2002) points out, however, that the progress psychologists have made in explaining mental illness has come at a high cost. He argues that relieving the states that make life miserable has made building the states that makes life worth living less of a priority. Seligman contends that people want more than to correct their weaknesses and believes that they aspire to experience lives imbued with meaning, not just to simply exist until they die.

For several decades various academic papers promoted the idea that we have a fixed range for happiness, which does not allow us to be lastingly happy (see

Brickman & Campbell, 1971). New empirical evidence however is accumulating which contradicts this conviction. More recent research demonstrates that happiness can be maintained and increased over time (Seligman, Steen, Park & Peterson, 2006).

After he reflected upon the limitations of the psychological literature, Seligman considered it worthwhile to develop a science that seeks to understand **positive emotion**, build **strength** and **virtue**. A science that could provide guideposts to help people pursue **happiness**. As such he decided to develop the field of *Positive Psychology,* aiming to place the study of human happiness onto a firm scientific foundation and to add some positivity to the predominantly negative discipline of psychology.

The field of positive psychology is dedicated to the scientific study of strengths and virtues that could enable individuals and communities to flourish. This field is founded on the belief that people desire to experience meaningful and fulfilling lives, to cultivate what is best within themselves and to enhance their practices of love, work and play. Snyder and Lopez (2005) argue that the positive psychology movement offers a rare opportunity for a re-orientation and deconstruction of our views of psychology, through a reconstruction of our views of psychological health, human adaptation and adjustment.

Following the development of the positive psychology movement, rather than focusing exclusively on the negative experiences or perceptions of individuals, psychologists began to consider also investigating the ways in which human virtues and strengths promote positive mental health. Positive psychology related research has empirically scrutinized positive constructs such as optimism, resiliency, self-control, self-efficacy, benefit finding, spirituality and hope.

Seligman (2002) proposed that the field of Positive Psychology comprises three main areas of research:

- The study of **Positive Emotions** – such as joy, interest, contentment, and love.

- The study of **Positive Traits** – foremost amongst them the strengths and virtues, but also the 'abilities' such as intelligence.

- The study of **Positive Institutions** – such as democracy, free inquiry and strong families that support the virtues, which in turn support the positive emotions.

An important contribution of positive psychology theory to the psychological literature has been the development of the Character Strengths and Virtues (CSV) handbook (Peterson & Seligman 2004). The handbook represents the first attempt on the part of the research community to identify and classify human beings'

positive psychological traits. The handbook describes in thorough detail twenty-four character strengths. These include:

Courage

Bravery, Persistence, Integrity, Vitality

Humanity

Love, Kindness, Social intelligence

Justice

Citizenship, Fairness, Leadership

Wisdom and Knowledge

Creativity, Curiosity, Open-mindedness, Love of learning,
Perspective and Wisdom

Temperance – **Strengths** that protect against excess

Forgiveness and Mercy, Humility and Modesty, Prudence, Self-Regulation [self-control]

Transcendence - Strengths that forge connections to the larger universe and provide meaning

Appreciation of beauty and excellence, Gratitude, Hope, Humour, Playfulness,

Spirituality

Froth (2004) argues that positive psychology shares many concerns of humanistic psychology and existentialism. The philosophy of existentialism had a significant impact on the development and growth of humanistic psychology. Both humanistic and existential psychology value the basic goodness in people and human potential. Existential therapy aims to help people to break away from a victim-like stance and instead find ways to create a meaningful life (Yalom, 1980). These are also concerns of positive psychology. The greatest difference however between positive psychology and the other two approaches is that positive psychology appears to favour a different research methodology. Existential psychologists and humanists tend to choose more qualitative methods so as to increase the chance of understanding the "whole person". They regard the use of quantitative methods in the study of the human mind and behaviour as misguided. Positive psychologists in contrast tend to employ more rigorous, quantitative, positivist and reductionist methods.

Humanistic psychology has been criticised because its theories are impossible to falsify and for lacking predictive power. Therefore, concern has been raised as to whether humanistic psychology is actually a science; since a good scientific theory should be falsifiable and have predictive power (see Seligman & Csikszentmihalyi, 2000). Equally, positive psychology can be criticised for not embracing qualitative research methodology as much as it embraces quantitative.

Froth (2004) argues that positive psychology mimics the ideas of humanistic psychologists such as Maslow. In 1954 long before the development of the positive psychology movement, Maslow argued that psychology has been far more successful in addressing the negative than the positive side. He also contended that psychology has revealed to us much about man's shortcomings, his illnesses, his sins, but little about his potential, his virtues, his achievable aspirations, or his full psychological height. Froth concludes that positive psychology will not self-actualise until it embraces its history and is more accepting of phenomenology.

1.1.1 Research Rationale

In past decades considerable research has demonstrated that social support can protect us from the potentially pathogenic influence of stressful events, by either attenuating or preventing a stress response (e.g. Bagley & Young, 1998; Lara, Leader & Klein, 1997). There have however been no systematic attempts to examine the ways in which social support and human strengths such as hope might contribute to happiness, life satisfaction and postive mental health. Therefore, little is known about the relationship between hope and subjective well-being depending upon the type of social support individuals perceive they have.

Seligman (2002) asks a question worthy of contemplation: In times of trouble, does the understanding and alleviating of suffering trump the understanding and building of happiness? He suggests that people who are impoverished, depressed, or suicidal, care about more than just the relief of their suffering. He proposes that these people care sometimes desperately about virtue, purpose, about integrity and meaning.

Unlike past investigations of hope and social support, the present study has adopted a positive psychology ethos. Traditional psychology draws upon the disease model and aims to assess the ways in which these two constructs help us to relieve our suffering and cope with adversity. In contrast the current research examines whether hope and social support predict subjective well-being by influencing our perceived life satisfaction. If hope and social support have a positive impact on our subjective life satisfaction, focusing on developing appropriate strategies to improve social networks and to cultivate hope, may lead us to enjoy life more. This research idea is in congruence with the objectives of positive psychology which aim to identify the factors that enable us to feel good and flourish in order to gain more pleasure from our lives.

1.2 Social Support

1.2.1 Conceptualisation and measurement

The mental health implications of social support started to receive much scholarly attention during the late 1960's. As a result research associated with social support increased rapidly over the following decades. Social support is a term used to describe a rather complicated concept. Unsurprisingly, conceptualizing social support has been problematic. There has been a lack of consensus regarding its operationalisation and definition amongst social scientists. Researchers have been making various implicit assumptions about how to conceptualise social support and subsequently there is considerable variation in the selection of measurement instruments. This makes it difficult to understand the available findings and also their implications for both theory and practical applications. Consequently, as there are differences in the theoretical conceptualism of the construct, instruments used to measure social support vary and as a result the nature of social support measured varies as well.

In an attempt to develop a measure that would be able to account for the multi-faceted nature of social support, Sherbourne and Stewart (1991) designed the Medical Outcomes Study Social Support Survey (MOS-SS). The MOS-SS is a brief, multidimensional, self-administered instrument. The instrument assesses four functional dimensions of perceived social support (*Emotional/Informational*, *Tangible*, *Affectionate*, and *Positive Social Interaction*).

1.2.2 Types of social support

Social support is a multi-dimensional concept that has been difficult to conceptualise, define and measure. In the psychological literature, social support is a general term that has been used to incorporate a range of different aspects of social relationships such as: emotional, practical and informational support and companionship (Vaux et al. 1986). Although different descriptions have been used to define social support, all the terminologies that have been employed imply that some type of positive interaction or helpful behaviour is provided to the person in need of support.

After reviewing the literature, Hupcey (1998) distinguished major theoretical definitions of social support into five categories. *Category one* involves the type of support provided. *Category two* is associated with the recipient's perception of support. *Category three* involves intentions or behaviours of the provider. *Category four* involves reciprocal support and finally *category five* involves social networks.

The multi-faceted nature of social support necessitates giving attention to factors which may interact in determining the level of support provided. According to Cohen and Syme (1985) these factors are: Who is providing the support? What kind of support is being provided? To whom is the support provided? For which problem is the support provided? When is the support provided? For how long is support provided? and finally, what are the costs of giving and receiving support?

Following the observation that social support has been defined in the psychological literature in several different ways resulting in different outcomes, researchers divided the concept into more carefully defined dimensions. Cohen & Syme (1985) sought to identify and distinguish between different dimensions of support in order to tap into the complexity of the concept. This led to the distinction between two different ways of conceptualising social support, the *structural* and *functional* perspectives. The issue is whether support is conceptualised in terms of the *structure* of an interpersonal relationship or social network, or in terms of the *functions* that a relationship or network serve. *Structural* social support refers to the quantity of the social network, such as how many friends a person has and how frequently he/she sees them. *Functional* social support refers to the quality of support and also the type of helping/supportive behaviour provided (McLeod, Baker & Black 2006).

More recently research effort has been directed at identifying whether each dimension of social support is independent of the others. For example, a study by Murrell, Norris & Chipley (1992) indicated that functional support and structural support contributed to happiness in older adults in different ways. Functional support had an enduring direct positive relationship to positive affect but neither influenced, nor was it influenced by events. This was in contrast to structural support, which did not have enduring direct effects on positive affect, but did influence and was influenced by events. Furthermore, Dobkin, et al. (2002)

interviewed adult substance abusers and found that higher levels of perceived functional support were related to more days spent in treatment and to higher rates of treatment completion.

1.2.3 Perceptions of social support

Sarason et al. (1991) argue that an individual's perception that they have a reliable and accessible social network is more important in reducing distress than whether or not the network is actually used. This idea is known in the psychological literature as the concept of *perceived social support*. According to Lakey & Cassady (1990) perceived social support is the subjective sense that people are available and willing to satisfy a range of roles that include emotional, friendship and tangible needs. Several researchers focused their attention upon investigating this concept (e.g. Rivera, et al. 1991; Lakey & Dickinson, 1994).

It has been shown that perceived social support is linked more consistently to mental health indicators than enacted (i.e. actual received) social support (e.g. Sarason et al. 1991). Brummett et al. (2005) found that perceptions of support positively influence recovery from a cardiac event. Torgrud et al. (2004) discovered that individuals with generalized social phobia score low on measures of perceived social support. They hypothesised that the cognitive and behavioural characteristics of individuals with generalized social phobia may be responsible for producing deficits in perceived social support. More specifically they argue

that the tendency of social phobics to interpret ambiguous social events and mild negative events in a negative fashion, could influence perceptions of support by affecting interpretations of others' social behaviour and attempts to support. The researchers also suggested that some individuals with generalized social phobia may limit the support received from others by appearing distant, making brief responses and appearing uninterested when engaging in social interactions. According to the researchers the avoidance of social situations could be another behavioural process that may reduce or even diminish the levels of support received.

1.2.4 Social support research in mentally ill populations

The psychological literature has a substantial number of empirical papers which have researched social support. Most of these studies however were designed to research mental illness and have utilised clinical samples. The belief underpinning this research is that social support is an important coping resource for those experiencing adversity. Theories and models have been proposed based on this rationale. For example, Wheaton's (1985) main effects model presumes that social support has a direct *cause-effect* and serves a health-restorative role by satisfying essential human needs for social contact, regardless of the level of stress present. This generalised beneficial effect of social support occurs according to Wheaton

because social networks provide positive interactions, support and affirmation that lead to an overall sense of self-worth, self-esteem and positive affect.

Turner-Cobb et al. (2006) found evidence which suggests that social support also plays a role in *moderating* the effects of stressors. This evidence supports a theory previously proposed by Cohen and Wills (1985) in which they argued that stress-buffering mechanisms of social support intervene between the stressful event and a stress reaction by attenuating or preventing a stress response. The theorists also suggested that adequate support may intervene between the experience of stress and the onset of a pathological outcome by reducing or eliminating the stress reaction or by directly influencing physiological processes.

In summary, the two most influential theories that aim to explain how social relationships influence mental health, are the main effects model and the stress buffering model. These two theories have generally been referred to as the health-sustaining *(direct-effects hypothesis)* and the stress-reducing (*buffering hypothesis*) functions of social support (Shumaker & Brownell, 1984). Research which has focused on testing these two models has provided some support for each idea. In order to illustrate the accumulated evidence in support of the validity of these theories a brief critical literature review of this research is outlined within this chapter. At the end of this short literature review, the rationale for examining social support in a positive psychology context will be further considered.

Research by Bagley and Young (1998) suggests that perceived social support, when present, positively influences the treatment outcome of female sufferers of child sexual abuse. Joseph et al. (1993) found that social support positively mediated the level of PTSD symptomatology when received in the immediate aftermath of a crisis. Furthermore, research by Lara, Leader and Klein (1997) suggests that social support significantly predicted recovery from depression over and above the effects of initial depression severity, dysthymia and neuroticism.

Ingram et al. (1999) investigated the potential significance of social support for depressed individuals living with H.I.V. Two measures of social support were utilised, the first was the Social Support Questionnaire (Sarason, Shearin, Price, & Sarason, 1987) and the second the Unsupportive Social Interactions Inventory (Ingram, Betz, Mindes, Schmitt & Smith, 2001). Correlational analyses indicated a significantly inverse relationship between *size* and *satisfaction* of social support network on depression scores. Multiple regression analyses revealed that higher levels of social support satisfaction were related to lower levels of depression. Size of social support network however did not obtain the same association. Of course the conclusions drawn in this study do not necessarily generalise to other depressed individuals, given the particular nature of the population under investigation and should be examined with regards to other depressed populations.

A retrospective self-report design was used by Morano and Cisler (1993) to look at social support and hopelessness amongst other variables. The Social Support

Questionnaire (Sarason, 1983) and the Beck Hopelessness Scale were utilised to measure these variables. A group of people with suicidal tendencies was recruited and the results were compared to a non suicidal control group. Participants were aged between thirteen to eighteen years old and were hospitalised within inpatient psychiatric treatment facilities. A racial and socio economic status bias was observed. All participants were Caucasian, middle-class adolescents. Two groups were formed; one with twenty participants who had attempted suicide and a second with twenty participants who had not attempted suicide.

The researchers modified the two measures so that the 'suicide attempt' participants were focused on the period just prior to the suicide attempt and the 'non suicide attempt' participants were focused on their experiences in the few weeks prior to hospitalisation. The Beck Hopelessness Scale also assessed the future expectations of the 'suicide attempt' group just prior to the attempt and the future expectations of the 'non suicide attempt' group. The researchers reported that the modified measures showed appropriate reliability and validity; however they did not provide precise data.

The value of family support as a buffer against serious vulnerability was strongly suggested by the results. Experience of loss and low family support were the best predictors of serious suicide attempts by adolescents. Those participants who experienced a loss and perceived that they had relatively little family support were more likely to have attempted suicide. Even though suicide attempters did not

report less support or less satisfaction with support than did non-attempters, they did report significantly less family support. Finally, suicide attempters reported more hopelessness than did the non-suicide attempters. In another study Joiner, (1997) found that low social support interacted with shyness in predicting severity of depressive symptomatology.

1.2.5 Research on social support within a positive psychology context

Social support can be characterised as a positive concept since there is sufficient evidence which suggests that it has a beneficial effect upon our mental health. Given that positive psychology research is still in its infancy, there is a lack of studies devoted to examining whether social support interacts with other positive constructs such as hope to promote positive mental health. It is not surprising that most research devoted to the examination of social support has utilised clinical populations. Psychological research and theory has mainly focused on explaining pathology based on the underlying belief that understanding abnormal processes can elucidate normal processes. In contrast research on positive psychology is aimed at expanding our understanding of how happy people who are satisfied with their lives function. This kind of research could give us useful insights into how to protect very unhappy people against psychopathology.

Diener & Seligman (2002) found that the happiest individuals reported strong positive social relationships. On the contrary, unhappy people were found to have

social relationships that were significantly worse than average. The findings of their study however are limited by the fact that the sample was restricted to college students. In addition, because the study was cross-sectional in design it is not possible to establish if rich social lives caused happiness, or vice versa, or if both were caused by some other variable.

Since previous studies to date have not assessed whether social support and hope aid our subjective well-being, this is a gap in the literature that is certainly worth exploring. Specifically, the present study attempts to investigate whether social support is related to hope, a construct which is also considered to cultivate human strength. In addition the study will investigate whether this hypothesised relationship positively influences our perceptions of how happy and satisfied with our lives we consider ourselves to be.

1.2.6 Personality styles and social support

The study of how different personality styles may impact upon an individual's actual or perceived social support has started to receive increased attention. There is evidence which support the idea that personality plays an important role in determining whether or not social support is available to people in times of need. Zellars & Perrewé (2001) argue that the inherent predisposition of extraverts to engage in more interpersonal activities might enable them to derive greater support than individuals with other personality styles. They found that their

extravert participants engaged in more interpersonal activities, which enabled them to derive greater support from co-workers. They also found extraversion to be related to emotional support. Agreeableness was also associated with the receipt of more support.

Cutrona Hessling & Suhr (1997) observed the interactions of one hundred married couples. They discovered that the extraversion of *support recipients* did not directly predict the amount of support they received from the spouse. Rather, the extraversion of *support providers* proved to be most important. They concluded that it is important to consider the personal dispositions of *support providers* as well as *support recipients* across a range of ongoing interdependent relationships, including marriage, parent-child relationships, sibling relationships, and close friendships.

McCann, Russo, and Benjamin, (1997) found that hostility was associated with a lower amount of perceived social support. Specifically, hostile, negative attitudes toward others were associated with perceptions of low support from colleagues and an interpersonally unpleasant workplace. Vogel & Wei (2004) examined individual differences that contribute to one's decision to seek professional support. They considered different types of insecure attachment styles. They found that individuals with insecure attachment types, such as anxiety and avoidant, did not report the same willingness to seek help. Individuals with attachment avoidance were found to be significantly less likely to seek professional support.

On the contrary, individuals with attachment anxiety were more likely to seek professional help.

In the absence of social support, shyness could be a vulnerability factor for depressive symptoms. Joiner (1997) found that shyness predicted changes in depressive symptoms over the course of the 5-week study, but only for those participants who reported low social support. Shy participants with higher social support scores experienced little symptom change.

1.2.7 Gender differences and social support

Sarason et al. (1985) argue that men and women engage differently in social relationships with others, and differ in the nature of support they look to obtain from these relationships. Females report receiving more social support than males (e.g. Sarason et al. 1987; Wohlgemuth & Betz 1991) and report providing more emotional support than males (Mickelson, Helgeson & Weiner 1995). Mickelson et als' study also suggested that recipients of social support reported that same-gender providers of support listened more than opposite-gender providers to their problems.

A study by Day & Livingston (2003) found that women reported that they would turn to their partner and friends for support to a significantly greater extent than men would. Women were also found to be significantly more likely to seek emotional support than men. Clarke et al. (2006) found that women were willing

to accept emotional support, but men felt that emotional support is inappropriate, even when diagnosed with a terminal illness. Men may feel more uncomfortable than women in discussing their difficulties. Greenglass and Burke (1988) argue that this could be because revealing vulnerabilities is inconsistent with the male masculine gender role. Sarason et al. (1985) discovered that the female participants from their study were significantly more socially skilled than their male participants. A study by Glynn, Christenfeld and Gerin (1999) found that social support from a woman is more effective at reducing blood pressure responses to stress in both men and women than is support from a man.

Nagurney, Reich and Newsom (2004) found that men who reported a higher (vs. lower) desire for independence (a desire to take care of oneself and to stand alone when dealing with problems), responded more negatively than women to receiving high levels of social support. Beehr et al. (2003) argue that although it is believed that women tend to assume traditional feminine characteristics and men assume more masculine characteristics, it is likely that these feminine and masculine role characteristics vary across individuals within each gender. They predicted that people with more feminine gender role characteristics would react more positively to social support than people with less feminine, or more masculine role characteristics. The results they obtained confirmed their prediction.

1.2.8 The influence of developmental changes on the experience of social support

Developmental changes are important because they signal a change in the nature and functioning of social support networks as people grow older. Stewart and Sun (2004) argue that supportive interactions with friends are mostly tied to young adults' psychological well-being. Levitt, Guacci-Franco and Levitt (1994) found that children reported receiving more support from extended family members at age ten and reported more friends and more support from friends at adolescence. Their results also indicated that the child's social network expands first through the addition of extended family members in middle childhood, with extended family relations becoming supplanted to some extent by friendship relations in adolescence.

A study by Milevsky (2005) highlighted the importance of sibling support in emerging adulthood. Milevsky investigated whether support from siblings is associated with psychological adjustment in emerging adulthood. Results indicated that those who received high sibling support scored significantly lower on measures of loneliness and depression and significantly higher on self-esteem and life satisfaction, than those under low sibling support conditions.

Marriage can change the nature of an individual's social support network. Kearns and Leonard (2004) argue that after marriage couples' networks become more *interdependent*. The concept of interdependence refers to the properties that reflect

the form and the degree to which network members are interlinked, such as interconnectedness, density, and network overlap. The results of their study suggested that the social networks of men and women were reshaped by marriage. After marriage an increased overlap began to emerge between husbands' and wives' friend and family networks, as well as increases in the percentage of time that the spouse was included in interactions with friends and family. The major period of change in network interdependence seems to occur from pre-marriage to the first year of marriage, whereas the interdependence of couples' networks appears to become relatively stable at that point.

On the contrary, Segrin (2003) argues that older adults show a preference for support from family members. Krause, Liang and Keith (1990) found that older adults who reported having increased contact with others (especially family members) also reported that they received more emotional support than did elderly people with less contact. Their results also indicated that greater amounts of emotional support tended to increase perceptions of support availability in the future.

1.2.9 Social support and well-being.

Several studies have shown that there is a strong association between well-being and social support. For example, Emmons and Colby (1995) found that negative perceptions and attitudes toward social support and in particular ambivalence over

expressing emotion and fear of intimacy, could play an important role in individuals reporting lower well-being.

Research which looked at the relationship between well-being and social support has recruited participants who are caregivers of individuals with chronic illness. Ergh, Hanks, Rapport and Coleman (2003) interviewed individuals who had sustained a moderate to severe traumatic brain injury and also interviewed their caregivers. They found that social support emerged as an important agent of well-being. Their results suggested that caregivers' perceptions of social support had both direct and moderated effects on their well-being. Caregivers with low social support reported the lowest level of well-being.

In another study Skok, Harvey and Reddihough (2006) interviewed forty three mothers of children with chronic disabilities. The researchers aimed to investigate whether severity of disability, perceived stress and perceived social support had an impact on caregivers' well-being. They found that mothers who reported receiving higher levels of social support also reported high well-being scores. Results also indicated that perceived social support had a slight to moderate mediating effect in the relationship between perceived stress and well-being.

Social resourcefulness (the individual's ability to use, covert and overt behaviors to prompt and direct the helping behavior of others, in order to maintain the social relationship), may have a positive impact on well-being. Rapp et al. (1998)

interviewed sixty-five primary caregivers of individuals with dementia living in the community. Their results suggested that the more caregivers used social resourcefulness skills, the better their health status, the higher their quality of life and the less depressed they were.

Pahl (2003) conducted a review of the literature which suggested that there is evidence for an association between social support and well-being. Pahl argues however that a closer look at this evidence shows that there is no general agreement on what is meant by social support, as it has been defined in various ways. This makes it difficult to understand the available findings and to draw any definitive conclusions from the results.

Diener and Fujita (1995) argue that resources are not directly related to well-being. They propose that the degree to which specific resources affect well-being, depends on how much these resources help people attain their valued goals. According to Diener and Fujita, if an asset they possess is not associated with helping the individual attain the state that he/she desires, it does not affect their well-being. Diener and Fujita suggest that people can maintain positive well-being by matching their goals to assets they possess.

1.3 Hope

1.3.1 Conceptualisation

Hope is a core construct of positive psychology. Similarly to social support it is considered to help us effectively adjust and cope with life. Magaletta and Oliver (1999) point out that "the concept of hope has been associated with the Western psyche since classical antiquity in both its secular and sacred traditions.…according to the Pagan Greek myth, hope was the last and only good spirit to escape from Pandora's box…..St. Paul exalted hope as one of the three most fundamental Christian virtues…..Dante identified the absence of hope with hell…..Pope wryly noted hope's perennial and perennially frustrating, nature" (p.540).

According to Borneman et al. (2002) hope provides life with meaning, direction and an optimistic focus. Jevne (2005) argues that hope is essential for our existence; it is so pervasive as to be core to human experience and survival. Kylma (2005) describes hope as a basic resource in life. Tiger (1979) proposed that to feel hopeful is a biological need. He assumes that the reason that religions arose is due to this inherent human need to be hopeful.

Many definitions of hope exist in the literature. The definition the Webster College Dictionary uses to describe hope is *"to expect or look forward to, with desire and confidence to a future event".* According to the dictionary, such perception

arouses and justifies hope. When writers such as Lewin (1938) and Menninger (1959) introduced the concept of hope to the psychological literature there was not much interest in the scientific community to research this concept. As Steed (2002) argues it was during the 1970's that hope began to receive some attention in connection to research associated with stress, coping and illness.

Hope has been conceptualized in the psychological literature both as a unidimensional and as a multidimensional construct. Before the 1990's academic publications such as Gottschalk's (1974) used definitions which conceptualised hope as a unidimensional concept. These definitions were based on the idea that hope involves an overall perception that goals can be met. Erikson's (1964) definition of hope is an example of this. Erikson defined hope as the "enduring belief in the attainability of fervent wishes, in spite of the dark urges and rages which mark the beginning of existence" (p. 115). Similarly, Miller and Powers (1988) defined hope as a state of being characterised by an anticipation of a continued good state, an improved state, or release from perceived entrapment.

These conceptualisations assume that one's thinking about goal-directed activities could influence the subsequent attainment of positive outcomes. However, although they relate hope to positive outcomes, they do not sufficiently explain the ways in which these outcomes are pursued.

Snyder and colleagues (1991) published a paper which unlike previous publications such as Erikson's (1964), views hopes as a bi-dimensional construct. This paper became particularly influential in hope research in subsequent years. The paper proposes a theory which defines hope as a cognitive set that is based on a reciprocally derived sense of successful (a) *Agency* (thoughts associated with goal-directed determination) and (b) *Pathways* (thoughts about planning ways to meet goals). This revised definition of hope assumes that human actions are *goal directed*. Goals are the targets of mental action sequences and they provide the cognitive component of the theory. Goals may be short or long term, but need to be of sufficient value to occupy conscious thought.

People must view themselves as capable of generating workable routes to their goals in order to accomplish them. Snyder et al's hope theory defines this process as *pathways thinking.* Pathways thinking is a mental action which is considered to involve thoughts of being able to generate at least one, and often more, functional routes to a desired goal. The production of several pathway cognitions is important when encountering obstacles. Snyder et al. (1991) found that individuals with high hope perceive that they are competent in finding alternative routes to reach their goals.

Agency thinking is the motivational component in hope theory. Agency thinking is defined as the individual's perceived capacity to use *pathways thinking* in order to accomplish desirable goals. Agency thinking is about starting to move and

continuing to progress along a pathway. According to Snyder et al (1991) agency thinking is important in all goal-directed thought. It has special significance when an obstacle is present, because it helps the individual to apply the requisite motivation to the best alternate pathway.

According to hope theory, an individual needs both pathways and agency thinking in order to have high hope. For example, person A who is looking for employment, can think of many different people to approach in order to arrange a job (i.e. high pathways thinking), but he/she may not be motivated to contact these people (i.e. low agency thinking). Without the necessary agency thinking the individual cannot be regarded as having high hope.

In contrast person B is highly motivated to find employment (i.e. high agency thinking), but cannot think of people to approach in order to arrange a job (i.e. low pathways thinking). For all their agency thinking, their lack of pathways thinking prevents them from having high hope. Therefore, it is not sufficient to have just pathways or agency thinking for an individual to have high hope. In summary, within Snyder's et al. (1991) theory, hope is not viewed as a uni-dimensional concept, but has two components which are interrelated and both are essential for an individual to have high hope.

Several self-report psychometric measures have been developed and validated to research Snyder et als' (1991) hope theory. These measures are the:

- Adult Dispositional Hope Scale (DHS; Snyder, Harris, et al., 1991) for measuring trait hope in adults).
- State Hope Scale (SHS; Snyder et al., 1996) for measuring situational hope in adults.
- The Dispositional Children's Hope Scale (CHS; for ages 8–15; Snyder, et al., 1997).

1.3.2 Research on Hope

Scott and Vaughn (2006) investigated the factorial validity of the Adult Dispositional Hope Scale (DHS). The study examined the proposed two-factor (Agency, Pathways) representation of hope theory proposed by Snyder et al (1991) and compared it to a model representing hope as a unidimensional construct. The researchers aimed to recruit a large minority sample, as they identified that previous validation studies had predominately recruited Caucasian samples. They examined the factor structure and the cross-ethnic measurement equivalence of the DHS.

Their results were consistent with the idea that hope is a multidimensional construct. The two-factor (pathways & agency) structure of the DHS was confirmed by their results, not only in the overall sample, but across male, female, caucasian and minority subsamples. Their results also suggested that the model representing the two-factor (agency & pathways) structure, fitted significantly

better than the one-factor model representing general dispositional hope across all of the samples. There were no significant differences in the factor pattern coefficients for the agency and pathways factors for (a) males and females and (b) caucasian and minority subsamples.

In support of Snyder et als' (1991) hope theory it has also been shown that people with high hope are generally better adjusted and motivated to work harder towards their goals. For example, a study conducted by Snyder et al. (1991), found that participants scoring higher on the Trait Hope Scale kept their hands in freezing water for significantly longer.

Within Snyder's et al (1991) hope theory the stressor represents that which is interfering with one's normal ongoing goal of being happy. When confronting a stressor, one must find alternative paths to attain the "normalcy" goal, in addition to being motivated to use those paths. Horton & Wallander (2001) researched hope in mothers who care for children with chronic physical conditions. Their rationale for studying this group was based on their observation that a child with a disability usually poses unique challenges for everyone involved in the child's life, especially for those responsible for the child's care. Their results indicated that in high-stress conditions, mothers reporting a higher level of hope exhibited less distress than those reporting a low level of hope.

Magaletta and Oliver (1999) examined associations between hope, self-efficacy, optimism and well-being. Their results suggested that *Agentic* thinking made an independent contribution to the prediction of well-being beyond that made by general self-efficacy. *Pathways* thinking made an independent contribution to the prediction of well-being beyond that made by optimism. The authors argued that *pathways thinking* seems quite similar to aspects of problem solving and generation of alternatives.

Hagen, Myers and Mackintosh (2005) used the children's Hope Scale and examined whether at-risk children's level of hope predicts adaptive behaviour, beyond the advantageous effects of social support and the detrimental effects of stress. They found that being hopeful predicted adaptive functioning. Their results suggested that children who were hopeful exhibited better adjustment, as they reported fewer internalising and externalising problems. This was the case even after researchers accounted for both social support and stress.

Snyder, Lehman, Kluck and Monsson (2006) discussed the implications of Snyder et als' (1991) hope theory for rehabilitation. They argue that patients with higher levels of hope may have more successful rehabilitation than those with lower hope. Specifically, they proposed that hope theory could be helpful in fostering adaptive rehabilitation processes through the use of specific intervention techniques. These technique could be aimed at creating clearer and more

sustainable goals, increasing *pathways* thinking and infuse greater goal-directed energy (*agency*).

1.3.2 Distinguishing between hope and false hope.

Psychologists generally agree that hope is a human virtue which facilitates adaptive coping and cultivates human strength. However, others such as Tomko, (1985) have pointed out that there are occasions when an individual has hope based on illusions about accomplishing desirable goals instead of reality. Tomko gives emphasis to the idea that there could be negative effects when an individual's hope is associated with "positive illusions." Snyder et al. (2002) defined this phenomenon as *false hope*. Scioli, Chamberlin and Samor (1997) argue that false hope contaminates the positive effects that hope offers by promoting wishful thinking and denial. They argue that false hope is a maladaptive delay in confronting reality.

Snyder and colleagues (2002) used hope theory as a framework in order to discuss and differentiate hope from false hope. They proposed that false hope occurs when:

- Expectations and response strategies are based on illusions rather than reality.
- Inappropriate goals are pursued.
- Poor methods or strategies are used to achieve desired goals.

They concluded that it would be inaccurate to describe hope as "false" when the available evidence has consistently shown that hope contributes to greater productivity and well-being in various life arenas. They encouraged researchers to empirically scrutinize the concept of false hope by directing attention to investigating questions such as:

- Whether false hope occurs when expectations and response strategies are based on illusions rather than reality?
- Does false hope occur when an individual is trying to pursue inappropriate goals?
- Whether false hope occurs when using poor methods or strategies to achieve desired goals.

1.3.3 Hope as a construct of positive psychology

Positive Psychology regards hope to be a construct which cultivates human strength. Hope is considered to enable us to lead meaningful and fulfilling lives, to cultivate what is best within ourselves and to make the best out of our life experiences. Positive psychologists believe that fostering hope could enable individuals and communities to flourish. Accordingly, hope research within a positive psychological context has a different focus, nature and objectives than in studies which have recruited mentally ill populations. In order to demonstrate this

this chapter will outline research which has focused on establishing the factors that lead to high achievement, happiness and fulfilment.

Curry et al. (1997) conducted three studies which had a positive psychology ethos. The studies aimed to explore the effects of hope in college student athletes' academic and sports achievement. The research was conducted following the observation that the role of hope had remained unexplored amongst personality researchers interested in individual differences in motivation. It had not been explored predominantly because a theoretical model of hope and the associated measurement instruments had not previously been available. The researchers utilised both the Adult Trait and State Hope Scales. It was predicted that higher levels of hope in student athletes would positively relate to their academic and sports achievement. An important methodological limitation was that one of the three studies recruited only female participants. Additionally, all three studies had a cross-sectional design which did not enable the researchers to examine students' performance over time. Results indicated that hope predicted superior athletic achievements and did so beyond projections related to various other state psychological measures (self-esteem, mood and confidence).

In an attempt to draw upon the methodological limitations of the previous study, Snyder et al. (2002) re-examined the role of hope in academic achievement in a six year longitudinal study. This time the study's design enabled researchers to focus on students' performances over their college careers. It was predicted that

higher hope scores would relate reliably to (a) higher overall grade point averages, (b) higher likelihood of graduating and (c) lower dismissal or dropout rates. Results showed that hope scores predicted college students' academic performances over the course of their undergraduate careers. All three hypotheses were supported. Higher hope scores predicted higher overall grade point averages. Additionally, higher hope scores predicted a greater likelihood of graduating from college and a lower likelihood of being dismissed because of poor grades.

Snyder et al. (2002) concluded that high hope students were more able to clearly conceptualise their goals than low-hope students, who were more ambiguous and uncertain about their goals. Specifically, because high hope students were attuned to their goals and were in control of how to pursue them, they were motivated and performed well academically. Snyder et al. (2002) also found that high-hope students were better than their low-hope student counterparts at breaking assignments into small steps that are sequenced toward a larger or long-term goal. High hope students were able to find multiple pathways to reach their goals and willingly try new approaches. This was significant in situations where they encountered educational impediments, as according to the researchers high hope students were effective at channelling their energies to new paths. Finally, according to Snyder and colleagues, another asset of high hope students involved their high levels of motivation. Due to their previous successful educational goal

attainments, high-hope students were likely to be filled with a sense of agency and the anticipation of future school successes.

A limitation of Snyder et als' (2002) study was that it did not utilise a measure of subjective well-being. Such a measure could have assessed whether high hope students were subjectively happier and more satisfied with their lives than the students who reported lower levels of hope. High hope individuals are more able to generate workable pathways to their goals in order to accomplish them and are more motivated to move and continue to progress along a certain pathway in order to attain desirable goals. We could therefore predict that they would also be happier and more satisfied with their lives than low hope individuals. If this hypothesis gains empirical support one objective would be to design and implement specific interventions to increase hope in low-hope individuals. This could enable them to be subjectively happier and to enjoy life more.

1.4 Happiness, Well-being and Subjective Well-Being

The concept of happiness and what constitutes a good life has been debated by philosophers and scholars since the ancient times. However, the scientific study of happiness did not begin until the 1970's and progressed slowly in subsequent years. Several people observed the slow advancement in understanding happiness. For example, Csikszentmihalyi (1999) states that "despite recognition on the part of human sciences that happiness is the fundamental goal of life, there has been

slow progress in understanding what happiness itself consists of" (p.821). Diener (1984) points out that for decades psychologists largely ignored positive subjective well-being, although human unhappiness was explored in depth.

Since the main focus of psychological research has been to examine negative constructs that are considered to ail the human mind such as anxiety, depression, obsessions, paranoia and delusions, little theoretical advancement in understanding happiness has been made for two millennia, since the time of Aristotle and other ancient philosophers. Positive psychology is a field which encourages research into factors that make life worth living. With the emergence of this field concepts such as happiness which have been historically overlooked by psychologists, will receive increasing attention.

1.4.1 Definitions of happiness

According to Griffin (2007) the English word ''happiness'' came from the noun ''hap'': what just happens, chance, luck - good or bad. The Webster College Dictionary uses several words to describe happiness, such as joyous, satisfied, pleased, agreeable, lucky and fortunate. Diener, (2006) suggests that in the academic literature the concept of happiness has been associated with various meanings. He points out that happiness can mean a general positive mood, a global evaluation of life satisfaction, living a good life, or the causes that make people happy, with the interpretation depending on the context. Diener argues that

it is difficult to find a clear conceptualisation for this term and to establish which meaning has the most rational significance.

One term that has been used in the psychological literature to describe happiness is well-being. Well-being is a concept which indicates desirable psychological outcomes. Goal theorists argue that individuals attain greater well-being when they move toward an ideal state, or accomplish a valued aim. According to Emmons (1992) if people make progress toward their goals and act in accordance with their values they are likely to be happy. Emmons argues that people have different goals and desires and therefore what makes them happy will differ.

Diener (1984) points out that the literature on well-being refers to how and why people experience their lives in positive ways, including both *cognitive judgments* and *affective reactions.* Diener suggests that research on well-being covers studies which have used diverse terms to define the concept, such as satisfaction, happiness, positive affect and morale. Emmons (1986) argues that one of the most widespread findings in the literature is that well-being consists of three primary components: *positive affect, negative affect and subjective life satisfaction.* Positive affect according to Emmons, consists of pleasant emotions or feelings such as joy and happiness, whereas negative affect consists of unpleasant feelings or emotions such as sadness and fear. Subjective life satisfaction is a measure of an individual's perceived level of well-being.

According to Norrish and Vella-Brodrick (2007), in the literature the terms happiness and subjective well-being have often been used interchangeably. However, Norrish and Vella-Brodrick point out that subjective well-being is more acknowledged as being a scientific term. Diener (2006) defines the term subjective well-being as the individual's current evaluation of his/her happiness.

1.4.2 Theories of happiness

Theorists have been discussing and debating the concept of happiness since ancient times. The ancient Greek philosopher Aristotle in his theory of ethics, discusses the notion of happiness which he refers to as *eudemonia* (meaning: happiness, flourishing). Within Aristotle's theory eudemonia is not an emotional state. It is about being all that you can and fulfilling your potential. His idea is that by living in a way that enables you to reach your full potential, you flourish and so you are capable of displaying the best version of yourself that you can be.

Aristotle believed that virtues are essential ingredients of happiness. He proposed that the practice of virtues leads to happiness. By virtues Aristotle meant the act of achieving balance and moderation. It was the act of living in balance and moderation that brought the highest pleasure according to the ancient philosopher. It is this way of life that Aristotle believed would lead to the greatest long-term value, to be happy. For Aristotle contemplation was the highest activity humans could engage in. According to his theory contemplation is the activity that refines

and discovers virtues. Carried out continuously, contemplation allows us to reach our potential.

Three contemporary theoretical approaches of happiness that are particularly influential have been proposed. These are:

- *Affect theory*
- *Dynamic Equilibrium (DE),* also called *Set Point theory of happiness*
- *Comparison theory*

According to Schwartz & Strack (1991) *affect theory* views happiness as a manifestation of how well we feel generally and seeks to identify well-being though relevant responses. This theory is based on Tomkins's (1963) ideas. Tomkins was a personality theorist who organised affects into discrete categories and connected each one with its typical response. Specifically, Tomkins distinguished between *positive, negative and neutral affects.*

Positive affects are according to Tomkins: (a) *Enjoyment/joy* which manifests in a typical response of smiling and lips wide and out (b) *Interest and excitement* which manifests in eyebrows down, eyes tracking, eyes looking and closer listening.

On the contrary, the *negative affects* according to Tomkins are: (a) *Anger/rage* – which manifests in frowning, a clenched jaw, or a red face, (b) *Disgust* - the lower lip raised and protruded, head forward and down, (c) *Dissmell* (reaction to bad

smell) - upper lip raised, head pulled back, (d) *Distress/anguish* - crying, rhythmic sobbing, arched eyebrows, mouth lowered, (e) *Fear/terror* - a frozen stare, a pale face, coldness, sweat and (f) *Shame/humiliation* - eyes lowered, the head down and averted blushing.

The neutral affects according to Tomkins are *surprise/startle* which manifests in raised eyebrows and/or eyes blinking. Tomkin's ideas had implications for well-being. He proposed that optimal mental health requires the maximisation of positive affect and the minimisation of negative affect.

Tomkin's idea of *affective responses* provided the basis for the development of the Affective Theory of Happiness (ATOH). According to this theory, happiness can be assessed through the identification of relevant responses. The more often a person experiences responses associated with positive affect, the happier he/she is considered to be. In summary, according to the ATOH happiness is not a cognitive phenomenon. Within this view we do not evaluate or calculate happiness. Instead, happiness is an emotional or affective state that is characterised by feelings of enjoyment and satisfaction (otherwise termed as a balance of positive affectivity).

Headey and Wearing's (1989) *Dynamic Equilibrium (DE) Model,* also known as the *Set Point* theory of happiness, is based on Brickman and Campbell's (1971) Hedonic Treadmill theory. It is a theory that has received much attention from social scientists investigating well-being. The theory concerns the idea that people

usually return to a baseline, equilibrium level, or set point of happiness following even major life events such as becoming a paraplegic, or winning a large sum in a lottery. According to Brickman and Campbell this is because people briefly react to good and bad events, but in a short time they return to neutrality.

Similarly, Headey and Wearing (1989) argue in their DE model that well-being remains consistent over the life span, even though current events in people's lives can either raise or lower their well-being temporarily. According to DE theory each person has a normal or equilibrium pattern of life events and a normal or equilibrium level of subjective well-being, both of which are predictable on the basis of stable person characteristics. Provided that the normal pattern of events is maintained, Headey and Wearing argue that there will be no change in subjective well-being. Therefore, according to the DE model only deviations from normal events change the normal level of subjective well-being. According to this model this change is usually temporary. Stable personality traits, which according to DE theory play a crucial equilibrating function, would lead the individual to revert to his or her normal levels (Hedonic Adaptation). DE theory sees the evaluation as a stable attitude towards life.

Brickman and Campbell's (1971) idea of hedonic adaptation provided the foundation for the development of the DE theory. The idea was appealing because it offered an explanation for the observation that people appear to be relatively stable in happiness despite changes in fortune. As Diener, Lucas and Scallon

(2006) highlight however, the major criticism of this idea is that it does not adequately reflect the experience of all people. They proposed five revisions to the Hedonic Treadmill model:

1. People do not have neutral setpoints. Instead, most people are happier than neutral most of the time.
2. All people do not have the same setpoint. Instead, people have different setpoints based on genetic/personality factors.
3. People do not have one setpoint. Instead, they have setpoints for positive affect, negative affect and life satisfaction, which can all move in different directions.
4. Setpoints are not cemented in place. Instead, some life circumstances can alter them.
5. All people do not adapt to life events in the same way. Instead, individual differences in adaptation cause some people to change setpoints and others to remain the same.

This revised viewpoint challenges the concept of hedonic adaptation and offers new potential to enable psychologists to make progress in understanding the factors which influence happiness.

Another influential theory which was proposed to explain happiness is *Social Comparison Theory.* This theory is based on Festinger's (1954) idea that we learn about our own abilities and attitudes by comparing ourselves with other people and their opinions. According to social comparison theory we mainly compare

ourselves with someone whom we believe to be reasonably similar to ourselves. In the absence of such a benchmark however, we will use almost anyone.

Social comparison theory proposes that happiness results from comparison and sees evaluation as a continuous judgment process. Evaluation involves the comparison of an individual's perceptions of life as it is, with ideas of how life should be. Within this theory evaluation of life is considered more or less a conscious mental process. It is associated with assessing the degree to which life as it is, meets standards of what life should be. The better the match between these two judgments, the happier the individual will be.

A core component of social comparison theory is the notion of a *standard*, or *standards*. The theory assumes that in order to be able to judge how happy our own mental state is, we need to have a standard for comparison. Comparison theory makes other people the standard - any other people. Standards of comparison are mental constructs which individuals develop. According to the theory standards differ. This is because they are affected by factors such as personality, a person's life history and the environment in which he or she lives. According to the theory these subjective standards do not necessarily match actual requirements for a good life, such as 'preservation of health', 'meaningful activity' or 'development'. As Veenhoven (1989) highlights people may therefore settle for less than possible, or may consider their life to be a failure if they have not managed to become a millionaire for example.

1.4.3 Hedonism - the affective constituent of happiness

The affective component of well-being has been theorised as being associated with an individual's (actual or perceived) *hedonic balance.* Schimmack et al (2002) point out that the concept of *hedonic balance* is defined as the balance between pleasant and unpleasant affect. According to Rudebusch (2001) the concept of hedonic balance is based on hedonistic theories originating from views expressed by ancient Greek philosophers such as Socrates and Protagoras. According to the concept of hedonism, the ultimate goal of all individuals is to maximize pleasure and to minimize displeasure. Kahneman, Diener and Schwarz (1999) argue that the closer people are to this goal the higher their hedonic balance is and consequently the higher their subjective well-being. Therefore, when a hedonist faces the question of what well-being consists of? They will answer 'the greatest balance between pleasures over pain'.

1.4.4 Happiness as subjective life satisfaction

Several people (i.e. Diener, 1984) have suggested that when we discuss what happiness consists of and we endeavour to establish whether someone is happy or not, all that matters is to ascertain whether that person is satisfied with his/her life. What could be a better measure of evaluating whether our lives are going well than our own judgments? According to Sumner (1996) within this perspective the

extent to which we evaluate our satisfaction with our lives is basically all that matters. This concept is defined in the literature as subjective life satisfaction.

According to Diener, Emmons, Larson and Griffin (1985), subjective life satisfaction is a measure of an individual's perceived level of well-being. This concept was introduced to the literature by Diener (1984). Diener proposed that subjective life satisfaction is a cognitive judgmental process, a global assessment of one's life as a whole. According to Diener subjective life satisfaction involves evaluations of one's life according to subjectively determined standards. The emphasis here is usually placed on an integrated judgment of the person's life. Measures may cover a period ranging from a few weeks, to one's entire life. Subjective life satisfaction is considered to be one factor in the more general construct of subjective well-being. Psychologists generally agree that subjective life satisfaction is an essential constituent of well-being.

Diener and colleagues (1985) developed a measure to assess subjective life satisfaction. The instrument which they called *'The Satisfaction With Life Scale' (SWLS),* assesses ways of endorsing or being pleased with one's life and personal welfare; ways of believing one's life is going well.

In a meta-analytic review, DeNeve and Cooper (1998) used nine literature search strategies to examine one hundred and thirty seven distinct personality constructs as correlates of subjective well-being. Their results suggested that personality

could be an important correlate of subjective life satisfaction. The personality traits that were found to be most strongly related to subjective well-being tended to deal with experience of emotions (emotional stability, positive affectivity, tension) and the explanations that people give for life events (repressive defensiveness, hardiness and trust).

Conscientiousness was the strongest positive correlate of subjective life satisfaction. Conscientiousness enables us to act according to the dictates of our conscience. This trait includes elements such as self-discipline, carefulness, thoroughness, organisation, deliberation and need for achievement. DeNeve and Cooper's study concluded that personality is not the only important predictor of subjective well-being. Demographic variables, such as health and socio-economic status are also as important.

Goldberg and Harrow (2005) found that poor subjective life satisfaction was associated with recurrent depression. A study by Bailey et al. (2007) found that goal directed determination, the *agency* component of hope theory, predicts subjective life satisfaction.

2.0 Methodology

2.1 Epistemological justification

In order to investigate the hypothesised relationships between hope, social support and subjective life satisfaction, the current study utilised a *quantitative* research methodology. Quantitative research is usually linked to the notion of science as objective truth or fact. This type of research aims to describe and explain what exists in the world in as accurate a way as possible. *Objectivity* in the study design, method of data collection and type of data collected is therefore paramount (Coolican, 1999). In contrast qualitative research is typically identified with the view that science is lived experience and subjectively determined (Silverstein, Auerbach & Levant, 2006).

The research aimed to investigate the hypothesised relationships between hope, perceived social support and subjective life satisfaction. It also aimed to formulate statements about these relationships which are generalisable to the wider population. This is not something that can be achieved using qualitative methods where the focus is more upon describing a phenomenon or experience and exploring subjective meaning and metaphors. Quantitative approaches by contrast aim to achieve an objective perspective on the hypothesised relationships between the study variables.

2.2 Hypotheses

The purpose of the current study was to examine if (a) hope and perceived social support are associated with subjective life satisfaction and (b) to determine whether hope and perceived social support are predictors of subjective life satisfaction. For this reason three main hypotheses were tested:

(1) That there would be a significant association between hope and subjective life satisfaction.

(2) That there would be a significant association between perceived social support and subjective life satisfaction.

(3) That hope and perceived social support will predict subjective life satisfaction

2.3 Research design

A cross-sectional within-subjects design was used to investigate the relationship between hope, different types of perceived social support and participants' reported subjective life satisfaction. There were two independent variables (IVs). The first IV was hope, which had two levels (*agency hope*: belief in one's capacity to initiate and sustain actions and *pathways hope:* belief in one's capacity to generate routes to reach goals). The second IV was *perceived social support* with four levels: *emotional/informational support, tangible support, positive social interaction and affectionate support.* There was one dependent variable (scores on the *subjective life satisfaction scale).*

2.4 Sampling considerations

Most of the studies which have so far examined hope and social support have recruited clinical samples. Unlike these studies the current research adopted a positive psychology ethos. It aimed to recruit people who are happy and satisfied with their lives. For this reason participants were recruited from the community. This decision was based on the idea that by conducting research on happy people who are satisfied with their lives, we can enhance our understanding of how these people function. Understanding how happy people function could help us to identify the factors which increase well-being. We could then develop methods to help people feel happier and more satisfied with their lives.

Recruiting participants from the community does not guarantee that these individuals will not be unhappy. The results of this study however suggest that on the whole participants were not found to be dissatisfied with their lives. This suggests that they cannot be considered as unhappy. This result was in congruence with the ethos the study aimed to adopt.

Participants were recruited from shopping districts in the following areas: Kingston Upon Thames (SW London), Stratford (East London), Ealing (West London) and Redhill (Surrey). These areas were chosen following consultation of the website of the Office for National Statistics to verify that they represent a good cross-section of society in terms of ethnicity and socioeconomic status.

Of the total one hundred and fourteen people who participated, twenty six (23%) completed the questionnaire online, fourteen returned the questionnaires by post (12%) and the remaining seventy four (65%) completed the questionnaires at the same time they were approached by the researcher.

Of those approached twenty two people stated that they would prefer to complete the questionnaires at home. They were provided with the appropriate materials and a stamped addressed envelope for the return of the questionnaires. Of these questionnaires, fourteen were actually returned, a response rate of 63%. Sixty two people stated that they would prefer to complete the questionnaire online, twenty six actually participated, a response rate of 42%.

2.5 Measures

2.5.1 *The Medical Outcomes Study Social Support Survey* (MOS-SS; Sherbourne and Stewart 1991; Appendix 7).

The MOS-SS was developed by Sherbourne and Stewart (1991) to measure multidimensional aspects of perceived social support. There are four subscales within this instrument: *emotional/informational support*, *tangible support*, *positive social interaction*, and *affectionate support*. It also has an overall functional social support index. A higher score for an individual scale or for the overall support index indicates more perceived support. The MOS-SS requests respondents to indicate how often they perceive each kind of support is available to them if they

need it. The instrument is a simple and easy to use method of assessing perceived social support.

The validation study (Shelbourne and Stewart 1991) found the MOS-SS to be a reliable and valid measure. The authors report that a pool of 2,987 participants responded to their 19 items, which demonstrated good internal consistency (alpha = 0.97). This measure showed good convergent validity when correlated with marital and family functioning (*rs* = 0.38 to 0.57), mental health (*rs* = 0.36 to 0.45) and loneliness (*rs* = 0.53 to –0.69). Discriminant validity was established with pain severity (*rs* = 0.14 to –0.21), physical symptoms and role limitations (*rs* = –0.14 to –0.21) and indicators of social activity (*rs* = 0.24 to 0.33).

2.5.2 *The Adult State Hope Scale* (ASHS; Snyder, Sympson, Ybasco, Borders, Babyak, & Higgins, 1996; Appendix 5).

The Adult State Hope Scale is a six-item questionnaire. It was developed on the basis of the theorised definition of hope as a cognitive set comprising *agency* (belief in one's capacity to initiate and sustain actions to attain goals) and *pathways* (belief in one's capacity to generate workable routes to attain goals) (Snyder et al. 1991). The questionnaire contains four *agency* items (e.g., "I energetically pursue my goals," and "I meet the goals that I set for myself"), four *pathways* items (e.g., "There are lots of ways around any problem," and "I can think of many ways to get the things in life that are most important to me"), and

four *distractor* items. Respondents rate how accurately each item generally describes them on an 8-point Likert scale *(1 = definitely false, 2 = mostly false, 3 = somewhat false, 4 = slightly false, 5 = slightly true, 6 = somewhat true, 7 = mostly true, 8 = definitely true).*

Feldman & Snyder, (2000) report several studies which have tested the reliability and validity of the State Hope Scale. Coefficient alphas have ranged from .81 to .95 for the measure as a whole, with pathways subscale alphas from .63 to .93 and agency subscale alphas from .83 to .95. The test–retest correlations have been shown to fluctuate considerably between any 2 days in a 29-day period, varying from a low of .48 to a high of .93.

Convergent validity has been demonstrated between scores on the State Hope Scale and the State Positive and Negative Affect Schedule and on ad hoc measures of significant events and cognitions. More specifically, the State Hope Scale correlated positively with positive affect and positively viewed events, and it correlated negatively with negative affect and negatively viewed events. The short-term malleability and responsiveness of the State Hope Scale also has been illustrated by experimental manipulation (Feldman & Snyder, 2000).

2.5.3 *The Adult Trait Hope Scale* (ATHS; Snyder, Harris, Anderson, et al., 1991; Appendix 4).

Like the Adult State Hope Scale the Adult Trait Hope Scale was developed on the basis of the theorised definition of hope as a cognitive set comprising *agency* and *pathways*. Unlike the Adult State Hope Scale however this questionnaire measures a stable, lasting and cross-situational form of goal-directed thinking. The scale contains four *pathways,* four *agency* items, and four distracter items. Respondents rate how accurately each item describes them generally on an 8-point Likert scale *(1 = definitely false, 2 = mostly false, 3 = somewhat false, 4 = slightly false, 5 = slightly true, 6 = somewhat true, 7 = mostly true, 8 = definitely true).*

The Adult Trait Hope Scale has been found to be a reliable and valid measure of the hope construct across a number of studies (see Snyder, 2002). Cronbach's alphas for the overall hope scale range from .74 to .88; alphas for the pathways subscale range from .63 to .86; and alphas for the agency subscale range from .70 to .84. The Adult Trait Hope Scale also has manifested a test–retest reliability of .82 over a 10-week interval. Studies also have produced good convergent validity for the scale. There have been positive correlations in the .60 to .80 range with scales designed to measure similar positive constructs, and negative correlations between .36 and .51 with scales intended to measure negative affect and psychological disturbance (Cheavens, Gum, & Snyder, 2000). The Trait Hope Scale has also exhibited adequate discriminant validity as evidenced by its

negligible correlations with measures with which it should not have relationships of any magnitude (e.g., private and public self-consciousness and intelligence; Snyder, Harris, Anderson, et al., 1991).

2.5.4 *The Satisfaction with Life Scale* (SWLS; Diener, Emmons, Larsen & Griffin, 1985; Appendix 6).

The SWLS is a five item scale that is designed to obtain an overall judgement of a person's life in order to measure the concept of *subjective life satisfaction*. Subjective life satisfaction is one factor in the more general construct of subjective well-being. Individuals indicate their degree of agreement or disagreement on a 7-point Likert-type scale *(1 = Strongly Disagree, 2 = Disagree, 3 = Slightly Disagree, 4 = Neither Agree or Disagree, 5 = Slightly Agree, 6 = Agree, 7 = Strongly Agree).*

The *SWLS* is a reliable instrument with reported alpha coefficients exceeding 0.80 across numerous studies (see Pavot & Diener, 1993). This measure has adequate test–retest reliability, with the original validation sample yielding test–retest correlation coefficients of 0.82 over a 2-month period. Regarding validity, scores on the SWLS have been demonstrated to significantly correlate with other measures of subjective well-being (e.g., Rosenberg Self-Esteem Scale) and personality characteristics related to positive psychological health (e.g., high extraversion and low neuroticism) (Diener et al., 1985).

2.5.5 *Demographic Questionnaire* (Appendix 8).

In addition to the validated questionnaires, a demographic questionnaire was developed by the researcher to collect participants' demographic information such as *gender*, *age*, *ethnicity* and *marital status*.

2.6 Ethical considerations

Approval for the study was granted by the City University Research Ethics Committee. People who were approached and asked whether they would be interested in participating were informed that deciding not to take part in this research would have no impact on them whatsoever. For those interested in participating, a statement of consent (Appendix 2) and a debriefing statement (Appendix 3) were provided.

Participants were informed that they may withdraw their consent and discontinue participation at any time without penalty or loss of benefit to themselves. Participants were made aware that the data collected as part of this research project would be treated confidentially, and that published results of this research project would maintain their confidentiality.

People were able to email or phone the researcher to request more information about the study. All information was collected anonymously and was kept strictly confidential. The data was stored anonymously in a non-networked, password protected computer. Paper questionnaires were kept securely locked in a cabinet

and will be destroyed three years after the completion of the study. The research did not use deception. Participants were made aware that if they have questions about their rights as participants in this research, or if they feel that they have been placed at risk, they may write to the researcher's supervisor, Dr Don Rawson, School of Social Sciences, Department of Psychology, City University, London.

The study did not include any questionnaires that were designed to be distressing. If however participants found answering any of the questions distressing and felt that they would like to speak to someone about it, the researcher provided several resources whom they could contact (see Appendix 3).

2.7 Piloting the questionnaire

The questionnaire was piloted in a sample of seven people. Through piloting the questionnaire the researcher hoped to assess the following:

- How long it takes to complete
- That the instructions are clear
- To check if people had any comments to make

All those who participated commented that they found the instructions clear. Two people commented about the layout of the questionnaire and specifically about increasing the font size. The font size in the questionnaire was therefore altered to take account of the comment. The small sample was comprised of friends and colleagues of the researcher and was therefore an opportunity sample. The data

obtained therefore was not integrated with the data obtained from the main study in order to ensure that it would not bias the results.

2.8 Procedure

Potential participants were approached by the researcher in shopping districts in the following areas: Kingston Upon Thames (SW London), Stratford (East London), Ealing (West London) and Redhill (Surrey). Those approached were asked whether they would be willing to take part in a study investigating well-being. Those who expressed an interest were given an information sheet (Appendix 1), which briefly explained the purpose of the study. This was to help them decide whether they would be interested in participating. The researcher also answered any questions that potential participants had. They were assured that their responses were confidential and anonymous. For those interested in participating, a statement of consent (Appendix 2) and a debriefing statement (Appendix 3) were provided. A questionnaire was also available to fill in, or to take home should they wish. A stamped addressed envelope was provided for the return of the questionnaires to those who decided to complete them at home. The information sheets contained a web link for those who wished to complete the questionnaires online.

People were able to email, or phone the researcher to request more information about the study. Those who decided to participate were asked to provide their responses to the Adult State Hope Scale (**ASHS**; Snyder, et al. 1996), the Adult

Trait Hope Scale (**ATHS**; Snyder et al. 1991), the Satisfaction With Life Scale (**SWLS;** Diener et al. 1985) and the Medical Outcomes Study Social Support Survey (**MOS-SS;** Sherbourne & Stewart 1991). The measures were administered in the following order: ATHS, SWLS, ASHS, MOS-SS.

3.0 Results

3.1 Analysis strategy

The data was analysed using SPSS 14.1 for Windows (2005). Participants' state and trait hope, perceived social support and subjective life satisfaction were examined by exploring the distribution of scores for the study measures. The internal consistency of each scale (and where appropriate their subscales) was assessed using Cronbach's alpha.

Parametric statistics were used as the requirements for parametric analysis were met (Tabachnik & Fidell, 2001). The data was at interval level. Histograms were plotted to assess the assumption of normal distribution. Kolmogorov-Smirnov tests were also performed in order to examine whether the scores on the scales and subscales were normally distributed. There was a sufficient sample size; a minimum of twenty possible scores per variable (Coolican, 1999).

Levene's test was used to test for the parametric assumption of homogeneity of variance. All tests were non-significant ($p > 0.05$) indicating that the variances were not significantly different. For the multivariate analyses Box's M tests were

used to test the assumption of homogeneity of variance-covariance matrices. As the associated p-values were non significant ($p > 0.05$) this assumption was not violated and it was deemed appropriate to use parametric statistics. The main analyses were carried out using multivariate analysis, principal components analysis and linear regression analysis.

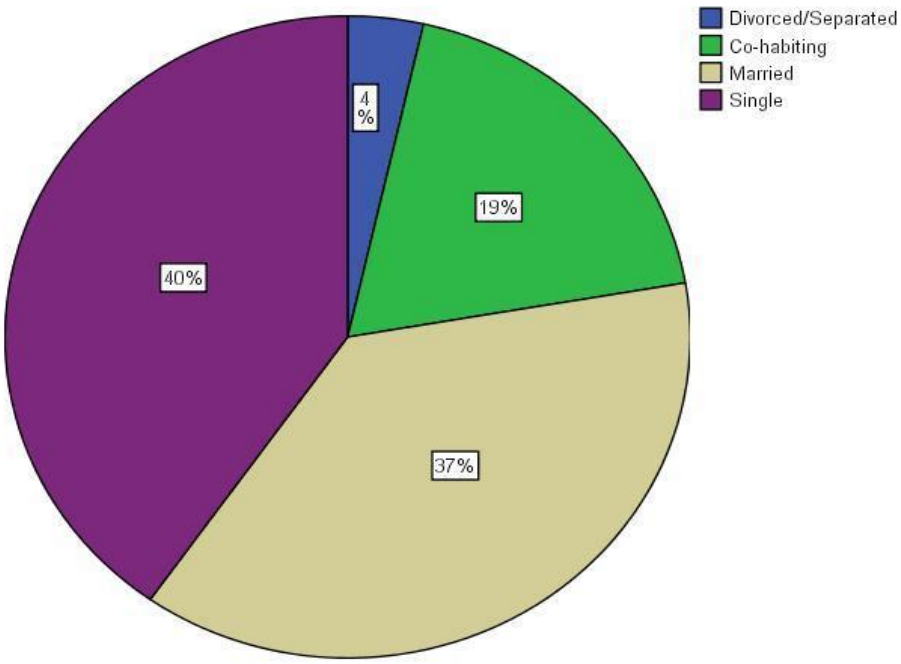
3.2 Sample characteristics

The study recruited 114 people, 97 (85.1%) of whom were female and 17 were male (14.9%). Table 1 displays the participant characteristics for the overall sample in terms of age, gender and ethnicity. Chart 1 provides a breakdown of participants' marital status. The average participant age was 32.27 years (S.D. 8.52). The age range was (21-65 years). The majority of participants were single or married (n = 89). Specifically, 39.5% of the participants reported that they were single, 38.6% that they were married, 18.4% that they were co-habiting and 3.5% that they were separated or divorced. Ethnicity was largely white caucasian (86.0%) with 1% Black/African, 7.0% Asian and 5.0% Other (5.0%). One percent of participants preferred not to answer this question.

Table 1. *Sample characteristics*

Overall sample (*n*=114)	
Demographics	
Gender (%)	
Male	14.9
Female	85.1
Age	
Mean	32.27
SD	8.53
Range	21-65
Ethnicity (%)	
Black/African	1.0
Asian	7.0
White Caucasian	86.0
Other	5.0
Prefer not to answer	1.0

Chart 1. *Participants' Marital Status (%)*



3.3 Reliability of questionnaires

Data analyses were conducted to examine the internal reliability of the questionnaires used. Reliability is the consistency with which something can be measured (Howell, 2002). The Cronbach alpha values for the ASHS, ATHS, SWLS and MOS-SS are illustrated in Table 2. The internal consistency of each scale including (where appropriate) their subscales was considered to be within acceptable limits (α = 0.79 - 0.94).

Table 2. *Internal Reliability Co-efficients (N = 114)*

	Cronbach's α
Adult State Hope Scale	
Agency state hope	.90
Pathways state hope	.81
Adult state hope scale overall scores	.90
Adult Trait Hope Scale	
Agency trait hope	.79
Pathways trait hope	.79
Adult trait hope scale overall scores	.85
Satisfaction With Life Scale	
Satisfaction with life scale overall scores	.90
The Medical Outcomes Study Social Support Survey	
Emotional / informational support	.97
Tangible support	.96
Affectionate support	.95
Positive social interaction	.94
Social support overall scores	.96

3.3.1 Adult State Hope Scale

Overall the scale was found to have good internal consistency (*a* = .90). The scale is comprised of two subscales. One of these subscales measures participants' *pathway* thinking (thoughts of being able to generate at least one, and often more, functional routes to a desired goal). The other measures *agency* thinking, which involves the individual's inclination to begin to move and continue to progress along a pathway in order to achieve a desired goal. Both these subscales demonstrated good internal reliability. Reliability coefficients ranged from .90 for the *agency state hope* to .81 for *pathways state hope* (see Table 2).

3.3.2 Adult Trait Hope Scale

Overall the scale was found to have good internal consistency (*a* = .85). Similar to the Adult State Hope Scale, this scale comprises two subscales, one for *trait pathways* thinking and one for *trait agency* thinking. Both these subscales demonstrated satisfactory internal reliability for trait pathways thinking (*a* = .79) and for trait agency thinking (*a* = .79).

3.3.3 The Medical Outcomes Study Social Support Survey

This scale comprises five subscales. All subscales demonstrated good internal reliability. Reliability coefficients ranged from .97 for *emotional/informational support* to .94 for *positive social interaction* (see Table 2).

3.3.4 Satisfaction With Life Scale

Overall the scale was found to have very good internal consistency (a = .90)

3.4 Descriptive Statistics

3.4.1 Hope

The Adult Trait and State Hope Scales were used to assess respondents' hope. Statistical exploration of these scales revealed that the sample as a whole, described themselves as being moderately hopeful both in a situational and a dispositional manner. This is indicated by the median scores for Trait Hope (total) and State Hope (total) presented in table 3.

There were no significant differences between participants' mean scores in the two subscales of the Adult Trait Hope scale namely, *Agency trait* and *Pathways trait*. The median scores on the two subscales of the Adult Trait Hope Scale suggest that respondents exhibited a thinking style that predisposes them to be moderately hopeful across different situations. Specifically, on the whole respondents reported moderate levels of cognitions about planning ways to meet goals and a moderate level of thoughts about goal-directed determination. The median scores for the Adult State Hope Scale suggest that on the whole respondents described themselves as having been in a moderate state of hopefulness when completing the questionnaires.

Table 3. *Descriptive Statistics*

	N	Minimum	Maximum	Mean	Median	SD
Pathways trait hope	114	12.00	32.00	22.83	23	4.58
Agency trait hope	114	11.00	32.00	23.35	23.5	4.65
Trait hope (total)	114	28.00	63.00	46.19	47	8.19
State pathways hope	114	6.00	24.00	16.34	16.5	4.02
State agency hope	114	5.00	24.00	15.80	16	4.68
State hope (total)	114	14.00	48.00	32.14	32	8.03
Subjective life satisfaction	114	6.00	35.00	22.86	24	6.64
Emotional/ informational support	114	1.25	5.00	3.92	4	.962
Tangible support	114	1.00	5.00	4.10	4.7	1.13
Affectionate support	114	1.00	5.00	4.12	4.6	1.11
Positive social interaction	114	1.00	5.00	4.03	4	.977
Global social support	114	1.32	5.00	4.00	4.1	.852

With regards to the Adult Trait and Adult State subscales (*agency* and *pathways)*, the median scores indicate that on the whole respondents reported moderate levels of dispositional and situational cognitions about planning ways to meet goals and goal-directed determination.

3.4.2 Social Support

The Medical Outcomes Studies Social Support Survey (MOS-SS) was used to assess respondents' perceptions about the extent to which they feel supported. The median score of global social support (4.1) indicates that overall, participants perceived themselves to be highly supported (see table 3).

The MOS-SS comprises four subscales, namely, *emotional/informational support*, *tangible support*, *affectionate support* and *positive social interaction*. The median score of the *emotional/informational support* subscale of the MOS-SS (4) indicates that as a whole the sample perceived that this type of support is available to them when they need it. Examination of the scores for individual items in this subscale revealed that 40% of the participants hold the view that *all the time* they have, *'someone they can count on to listen to them when they need to talk'*. Forty four per cent of the respondents endorsed that, most of the time, they have *'someone to talk to whose advice they really want'*.

Exploration of the data on the *tangible support* subscale of the MOSS-SS revealed that as a whole, the sample perceived that this type of support is available to them

when they need it. This is indicated by the median score (4.7) (also given in Table 3). Examination of the scores for individual items in this subscale revealed that 52% of the sample perceived that they have *'someone to help them if they were confined to bed'*, all the time. Fifty five per cent of them endorsed that they have *'someone to prepare their meals if they were unable to do it themselves'.*

The median score for the *affectionate support* subscale of the MOS-SS (4.6) (see also table 3), suggest that the sample as a whole perceived that this type of support is available to them when they need it. Sixty four per cent of the sample, agreed that they have *'someone who shows them love and affection'*, all the time. Sixty per cent of the respondents perceived that they have *'someone to love and make them feel wanted'* most of the time. Sixty per cent of the sample also reported that they have *'someone who hugs them'* all the time.

A similar picture to the other MOS-SS subscales emerged for the *positive social interaction* subscale. Respondents' median score (4) for the *positive social interaction* dimension suggested that the sample perceived that this type of support is available to them when they need it. Forty three per cent of the participants agreed that they have *'someone to do something enjoyable with'* all the time. Forty percent of the sample agreed that they '*have someone to have a good time with'* all the time. Thirty-nine percent of the respondents stated that they have *'someone to get together with for relaxation'*. In total only six participants (0.05%) perceived that positive social interaction was not available to them when they need it.

3.4.3 Subjective Life Satisfaction

The Satisfaction with Life Scale was used to assess participants' *subjective life satisfaction*. The descriptive data for this scale is also presented in Table 3. The median score (24) for this scale indicates that the sample as a whole perceived that they were slightly satisfied with their lives. Exploration of the data provided by this scale revealed that there was substantial individual variation in respondents' ratings regarding their perceptions of how satisfied they are with their lives. Ten per cent of the sample reported that they are extremely satisfied with their lives; twenty eight percent indicated that they are satisfied; twenty seven per cent stated that they are slightly satisfied with their lives; nineteen per cent suggested that they are slightly dissatisfied with their lives; eight per cent that they are dissatisfied with their lives and 3% reported that they are extremely dissatisfied with their lives. Twenty six per cent of the sample agreed that 'so far they have got the important things they want in life'. 21% of the respondents however, slightly disagreed with the statement 'if I could live my life over, I would change almost nothing'.

3.5 Associations between study variables

3.5.1 Correlates of subjective life Satisfaction

In order to examine the relationship between subjective life satisfaction and hope two-tailed Pearson Product Moment correlations were conducted. The correlation coefficients are presented in table 4.

Table 4. Pearson correlations between subjective life satisfaction (SWLS), trait hope (ATHS) and state hope (ASHS) (*N* = 114).

	Subjective Life Satisfaction
Adult State Hope Scale	
Agency state hope	.57**
Pathways state hope	.31**
Adult state hope scale overall	.49**
Adult Trait Hope Scale	
Agency trait hope	.57**
Pathways trait hope	.18*
Adult trait hope scale overall	.43**

*p < .05 (two-tailed); **p < .001 (two-tailed)

Table 4 illustrates that subjective life satisfaction was found to correlate significantly with:

Agency state hope, suggesting that the more participants had thoughts about goal-directed determination, the more likely they were to be satisfied with their lives.

Agency trait hope, indicating that the more participants subscribed to a dispositional thinking style that fostered goal directed determination to attain goals, the more likely they were to report being satisfied with their lives.

Pathways state hope, where stronger perceptions about planning ways to meet goals were related to higher subjective life satisfaction

Pathways trait hope, suggesting that the more participants adhered to a thinking style that predisposed them to plan ways to meet their goals, the more likely they were to perceive that they were satisfied with their lives.

Significant correlations between participants' global *state* and global *trait* hope and subjective life satisfaction were also found. This suggested that on the whole the more participants subscribed to a situational and dispositional cognitive set of:

(a) *agency* - thoughts associated with goal-directed determination and

(b) *pathways* - thoughts about planning of ways to meet goals, the more likely they were to report that they are satisfied with their lives.

3.5.2 The relationship between Perceived Social Support and Subjective Life Satisfaction

The association between subjective life satisfaction and different types of perceived social support were examined using Pearson Product Moment correlations. The results are presented in Table 5.

Table 5. Pearson's correlations between subjective life satisfaction (SWLS) and perceived social support (MOS-SS) including the four subscales (N = 114).

	Subjective Life Satisfaction
Emotional / informational support	.50**
Tangible support	.31**
Affectionate support	.52**
Positive social interaction	.41**
Global social support (overall score)	.54**

**p < .001 (two-tailed)

Subjective life satisfaction was found to be significantly associated with all four dimensions of the MOS-SS in addition to the overall perceived social support score (*global perceived social support*).

Specifically, significant correlations were found between subjective life satisfaction and:

Emotional/informational support, with greater emotional/informational support associated with greater perceived life satisfaction.

Tangible support, with stronger perceptions of having tangible support available when they need it related to higher perceived subjective life satisfaction.

Affectionate support, with stronger perceptions that someone is available to provide them with affectionate social interaction when they need it related to higher subjective life satisfaction;

Positive social interaction, with stronger perceptions of having someone available to have a good time with, associated with greater subjective life satisfaction.

There was also a significant correlation between *global social support,* as obtained from the four different types of the social support measured by the MOS-SS, and subjective life satisfaction. This suggests that the more respondents' perceived they had someone available to provide them with various kinds of support when they needed it, the more likely they were to report being satisfied with their lives.

3.5.3 Correlates of hope

Trait hope

Pearson Product Moment correlations assessed whether there were significant associations between participants' *trait* and *state* hope and the various kinds of perceived social support namely, *tangible support, affectionate support, emotional support* and *positive social interaction.*

Global trait hope, which refers to participants' overall trait hope scores, was associated with emotional Support ($r = .28$, $p < 0.01$), affectionate support ($r = .26$, $p < 0.01$), positive Social Interaction ($r = .27$, $p < 0.01$), and global social support ($r = .26$, $p < 0.01$). Global social support refers to the total score obtained across the four types of social support measured.

Pathways trait hope which refers to participants' disposition to have thoughts about planning of ways to meet their goals, was associated with positive social interaction ($r = .20$, $p < 0.05$).

Agency trait hope, a term which refers to a participant's tendency to have thoughts associated with goal-directed determination, was associated with emotional support ($r = .35$, $p < 0.01$), affectionate Support ($r = .32$, $p < 0.01$), positive social interaction ($r = .27$, $p < 0.01$) and global social support ($r = .31$, $p < 0.01$).

State hope

State hope refers to participants' situational rather than dispositional hope. Participants' scores on the measure of state hope and on the MOSS-SS revealed that global state hope was associated with: emotional support ($r = .39$, $p < .0.01$), affectionate support ($r = .33$, $p < .0.01$), positive social interaction ($r = .93$, $p < 0.01$) and with participants' overall social support scores ($r = .39$, $p < 0.01$). Global state hope refers to a multidimensional concept that according to Snyder's Hope theory, comprises cognitions about 'will to accomplish goals' and 'the ways to use their will to obtain them.'

The two adult state hope subscales were developed to elicit participants' *pathways* and *agency* cognitions. From examination of these subscales it appeared that respondents' pathways state cognitions (situational thoughts about planning ways to meet their goals), were associated with emotional support ($r = .27$, $p < 0.01$), positive social interaction ($r = .32$, $p < 0.01$) and with the overall social support scores ($r = .25$, $p < 0.01$).

Participants' agency state cognitions were associated with emotional support ($r = .44$, $p < 0.01$), affectionate support ($r = .39$, $p < 0.01$), tangible support ($r = .20$, $p < 0.05$) and with their overall perceived social support scores ($r = .45$, $p < 0.01$). Agency state cognitions refer to the thoughts respondents have about goal-directed

determination, which according to Hope theory enable them to use *Pathways thinking* in order to accomplish desirable goals.

3.6 One way ANOVA for gender differences

A one way ANOVA was conducted to assess whether there were significant differences between male and female respondents in self reported hope, social support and subjective life satisfaction scores. However, no significant differences were identified between the two groups.

3.7 Multivariate analysis for marital status group differences

Multivariate analysis was carried out to assess whether there were significant differences between the different marital status groups in respondents' self reported hope, perceived social support and subjective life satisfaction scores. As 86% of the respondents reported being of white/Caucasian ethnic origin and there was an insufficient number of participants in the other ethnic groups, it was not appropriate to conduct an analysis of the differences between the various ethnic groups.

Following guidelines from Dancey and Reidy (2004) the separated/divorced group was excluded from the analysis as it had an insufficient number of participants (n=4). Analyses were therefore conducted on the remaining 110 participants. Significant differences were identified between the groups on tangible support

($F(2,107) = 3.26$, $p<.05$) and affectionate support ($F(2,107) = 4.97$, $p<.01$) (see table 6).

Table 6. Mean scores for Tangible and Affectionate support by Marital Status

	Cohabiting (n=21)		**Single** (n=45)		**Married** (n=44)		**Total** (n=110)	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Tangible support	4.5	(0.8)	3.9	(1.3)	4.3	(1.0)	4.1	(1.1)
Affectionate support	4.4	(1.0)	3.8	(1.1)	4.4	(1.0)	4.1	(1.1)

As the MANOVA identified a significant difference between the marital status groups in mean tangible and affectionate support scores, post hoc tests were conducted to establish where the significant differences lay. Tukey-Kramer post hoc tests were chosen as there were an unequal numbers of participants across the three marital status groups (Howell, 2002). The test found that the single group differed from the cohabiting group on perceived tangible support ($p=.048$) and perceived affectionate support ($p=.046$). The single group also differed from the married group on perceived affectionate support ($p=.016$).

3.7 Principal Components Analysis (PCA) for Social Support (MOS-SS).

Given that social support is a construct that has been difficult to operationalise and measure, a principal components analysis was conducted in order to look for factor analytic evidence for the construct validity of the items of the MOS-SS.

PCA with rotation was performed, as rotation is considered to make the solution easier to interpret, without changing fundamental mathematical properties (Child, 1990). In particular, Varimax rotation was applied because it simplifies factors by obtaining an uncomplicated structure, which enhances the interpretability of the principal components/factors (Dancey & Reidy 2004).

Results indicated that all four factors from the original validation study were clearly defined, with only one discrepancy. Item 17 which should have loaded onto the *positive social interaction* factor only, also loaded onto the *emotional/informational support* factor. The *emotional/informational support* factor therefore consisted of items 1-8 plus item number 17 (see table 7).

The four factors accounted for 87% of the variance. Overall the results of the factor analysis suggested that the construct validity of the MOS-SS is very good with the exception of item 17, for which both meanings of *emotional/informational Support* and *positive social interaction* can be attached to it.

Table 7. Principal components analysis for Social Support (MOS-SS items)

Rotated Component Matrix[a]

	Component			
	Emotinal/ Informational Support	Tangible Support	Affectionate Support	Positive Social Inreraction
MOSSSQ3	.854			
MOSSSQ7	.847			
MOSSSQ4	.838			
MOSSSQ8	.819			
MOSSSQ5	.816			
MOSSSQ6	.798			
MOSSSQ1	.787			
MOSSSQ2	.763			
MOSSSQ11		.927		
MOSSSQ10		.902		
MOSSSQ9		.877		
MOSSSQ12		.870		
MOSSSQ14			.911	
MOSSSQ15			.858	
MOSSSQ13			.837	
MOSSSQ18				.852
MOSSSQ16				.816
MOSSSQ17	.410			.782

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.
a. Rotation converged in 5 iterations.

The first factor (perceived emotional/informational support) accounted for 60% of the variance. The second factor (perceived tangible support) accounted for 12.6%. The third factor (perceived affectionate support) accounted for 8.2%, whilst the fourth factor (perceived positive social interaction) accounted for 6.3% of the variance.

3.7 Principal Components Analysis (PCA) for Hope and Social Support

The aims of conducting Principal Components Analysis were to reduce a large number of variables into a more manageable set of factors/components and to test the theoretical models that the questionnaires were based on. It was hoped that PCA would produce principal components or factor scores which would be used as predictor variables to study the variability of subjective life satisfaction by conducting Multiple Linear Regression analysis.

PCA with rotation was performed, as rotation is considered to make the solution easier to interpret. In particular, Varimax rotation was applied because it simplifies factors by obtaining an uncomplicated structure, which enhances the interpretability of the principal components/factors.

Whilst deciding how many factors were needed to represent the data, the Kaiser criterion was applied. Thus only eigenvalues of 1.00 or higher were considered (Tabachnick & Fidell, 2001). Examination of a scree plot of eigenvalues, which was plotted against the factor numbers, suggested that the appropriate choice was to select two factors. The two-factor model accounted for 75% of the variance. The solution obtained was clearly interpretable and the two factors were easily defined. The first factor which was defined **Hope** accounted for 51% of the total variance. This factor incorporated respondents' *trait* and *state* overall scores and *state* and *trait* pathways and agency cognitions (see table 8).

The second factor which was defined **Social Support** accounted for 24% of the total variance. This factor was comprised of the four dimensions of the MOS-SS namely: emotional support, positive social interaction, tangible support, affectionate support and respondents' overall social support score (see table 8). The two factor model strongly confirmed the theoretical frameworks upon which the questionnaires were based. It also provided support to the idea that both hope and social support are multi-dimensional constructs.

Table 8. Confirmatory Principal Components Analysis PCA for Hope and Perceived Social Suport

	Component/Factor	
	HOPE	**SOCIAL SUPPORT**
Global Trait Hope	.926	
Global State Hope	.889	
State Pathways Cognitions	.860	
Trait Pathways Cognitions	.831	
Trait Agency Cognitions	.811	
State Agency Cognitions	.785	
Global Social Support		.978
Emotional Support		.859
Positive Social Interaction		.800
Tangible Support		.774
Affectionate Support		.750

Extraction Method: **Principal Component Analysis**. Rotation Method: **Varimax with Kaiser Normalization**. Rotation converged in 3 iterations.

3.7 Exploratory Multiple Linear Regression Analyses

Stepwise multiple linear regression analyses were conducted in order to identify the variables that best accounted for subjective life satisfaction. In order to reliably conduct a multiple regression Tabachnick and Fidell (2001) recommend that *n* should be > = 104 + m, where m = the number of independent variables. In the current study there are eleven independent variables. Therefore the study sample size of 114 closely matched these recommendations.

The stepwise approach was conducted as it results in the most parsimonious model (Dancey & Reidy 2004). This test allows us to examine if the explanatory variables of hope and perceived social support, either separately or combined, are significant predictors of subjective life satisfaction. Reported subjective life satisfaction as measured by the SWLS was entered as the dependent variable. The factor scores of hope and perceived social support obtained from the previous factor analysis were entered as independent variables. The (results of the multiple regression analysis for subjective life satisfaction is illustrated in table 9.

As can be seen from table 9, the factor *social support* obtained from the factor analysis was entered first into the stepwise multiple regression and accounted for 24% of the variance in subjective life satisfaction ($F_{1,112} = 35.92$, $p < .001$). The factor hope was entered second and explained a further 16% of the variance (F

1,111 = 31.49, p <.001). Both factors accounted for 40% of the variance in subjective life satisfaction.

Table 9. Stepwise multiple regression of predictors of subjective life satisfaction

Variable	*Multiple R*	*B*	*Standard error b*	*Beta*	*t*	*Significance of t*
HOPE	0.49	3.27	0.48	0.49	6.76	0.001
SOCIAL SUPPORT	0.64	2.71	0.48	0.41	5.61	0.001

In addition to looking at how much variance in subjective life satisfaction was accounted for by the factors hope and social support obtained from principal components analysis. The contribution of the individual dimensions of hope and social supported was also examined.

The age variable was not correlated significantly with any of the independent variables or the criterion variable (subjective life satisfaction). Therefore, it was not entered in the Multiple Regression Analysis as a predictor variable. All the other independent variables were found to be significantly associated with the criterion variable (subjective life satisfaction). They were all entered into the stepwise multiple regression analyses as predictor variables. *State agency* was

entered first into the stepwise multiple regression and accounted for 32% of the variance in subjective life satisfaction (F 1,112 = 55.42, p <.001). *Global social support* was entered second and explained a further 10% of the variance (F 1,111 = 19.38, p <.001). *Trait agency* and *global trait hope* accounted for an additional 6% (F 1,110 = 12.75, p <.001) and 3% (F 1,109 = 7.03, p <.01) respectively. The model accounted for 50% of the variance in subjective life satisfaction.

4.0 Discussion

The primary concerns of the study were firstly to investigate whether hope and social support, two concepts that are considered to cultivate human strength, are associated with subjective life satisfaction. Secondly, to examine the role of these variables in predicting subjective life satisfaction. To the best of the researcher's knowledge, this is the first study that examines hope and social support in assessing subjective life satisfaction. When interpreting the results, it is necessary to be mindful that the sample was predominantly comprised of Caucasian females. This affects the external validity of the study and limits us from being able to generalise the results with confidence to a wider population.

It was encouraging to notice, that respondents were moderately hopeful both in a dispositional and a situational manner. On the whole, participants reported moderate levels of dispositional thoughts about planning ways to meet goals *(pathways)* and thoughts about goal-directed determination *(agency)*. Moreover,

respondents scored consistently high on the social support subscales, suggesting that overall they perceived themselves to be adequately supported. Finally, more than half of the respondents considered themselves to be at least slightly satisfied with their lives. Most of these satisfied participants reported being at least moderately satisfied.

4.1. Participant Differences

The data indicated that there were not significant differences between males and females across any of the variables. However, the groups had unequal size which is known to interfere with statistical analysis (Tabachnik & Fidell, 2001). It is possible that gender differences exist but were not detected.

4.2 Validity of the Social Support measure (MOS-SS) and the Trait Hope (ATHS) and State Hope (ASHS) scales.

The results of the Principal Components Analysis were as might be expected and provided support for the theories the questionnaires were based on. The ideas that hope and social support are multi-dimensional constructs, as originally proposed by Snyder et al. (1991) for hope and Sherbourne & Stewart, (1991) for social support were confirmed by the results. Specifically, as anticipated, the Principal Components Analysis suggested that hope taps into the two differing dimensions of *agency* cognitions, (belief in one's capacity to initiate and sustain actions in

order to obtain goals) and *pathways* cognitions, (belief in one's capacity to generate routes to reach goals). The results of the factor analysis also indicated that the concept of social support is multidimensional and encompasses different types of support provision namely, *emotional/informational support*, *tangible support, affectionate support* and *positive social interaction*. Finally, the Principal Component Analysis suggested that the measurement quality of items associated with the dimensions of the Adult Trait Hope Scale (ATHS), Adult State Hope Scale (ASHS) and the Medical Outcome Study Social Support Survey (MOS-SS), is generally good as each dimension loaded onto its respective domain.

4.3 Correlations

The hypotheses that hope and social support would be significantly associated with subjective life satisfaction were confirmed by the results. However, since this was a cross-sectional study, it is not possible to infer cause and effect. The *agency*, *pathways* trait and state subscales, (ATHS & ASHS) as well as the dimensions of perceived *social support* (MOS-SS) were found to be significantly associated with subjective life satisfaction (as measured by the SWLS). The size of the correlation coeffcients were interpreted following recommendations by Cohen (1988). These relationships ranged from high to moderate in strength. There was only one low correlation between *pathways* trait hope and subjective life satisfaction, but it was also statistically significant.

The strongest correlation obtained was between *state* and *trait agency* cognitions and *subjective life satisfaction*. Specifically, those who had stronger dispositional and situational thoughts about being able to obtain goals were significantly more likely to evaluate their lives in a positive manner. Situational and dispositional *global hope* also correlated significantly with subjective life satisfaction. Specifically, people with greater situational and dispositional thoughts about being capable of obtaining goals and thoughts about finding ways that would enable them to obtain these goals, were likely to report high levels of subjective life satisfaction. These associations were moderate in strength.

With regards to social support, *global social support* was the strongest correlate of subjective life satisfaction. This means that the stronger someone perceived that they had various types of support available when they needed them, the more likely they were to evaluate their lives in a positive manner. *Affectionate* and *emotional support* respectively emerged as the second and third most significant correlates of subjective life satisfaction. The weakest correlation observed was between *tangible support* and subjective life satisfaction, but that was also significant.

Significant correlations were also found between the hope and perceived social support subscales. The most consistent correlate of perceived social support was the hope *state agency* subscale. The strongest correlations observed were between hope *state agency* and *emotional support* and *affectionate support*. Specifically,

those with the strongest perceptions of being able to obtain goals were significantly more likely to report perceiving that emotional and affectionate support was available to them when they needed it. Hope *State agency* also correlated highly with positive social interaction.

4.4 Predictors of Subjective Life Satisfaction

Of significance is the finding that when the dimensions of hope and social support were entered into a multiple regression analysis, *state agency*, a term which refers to goal directed determination, emerged as the strongest predictor of subjective life satisfaction. This suggests that perceiving that one can obtain goals, leads to increased subjective life satisfaction, more than any other of the variables examined by the current study.

When the two factors of hope and social support obtained from the Principal Components Analysis were entered into the Linear Regression Analysis, it appeared that the factor *social support* accounted for more variance in subjective life satisfaction than the factor *hope*. This suggested that the combined effects of different dimensions of social support accounted for more variance in subjective life satisfaction than the combined effects of hope. This suggests that on the whole social support could be a stronger predictor of subjective life satisfaction than hope. People may evaluate their lives more positively the more they perceive that different kinds of social support are available when they need them. This finding is

consistent with the idea that social support has a direct effect on psychological well-being as suggested by the main effects model.

4.5 Summary of results

The main hypotheses examined were supported by the results. All the dimensions of hope and social support were found to relate significantly with subjective life satisfaction. *Agency,* which refers to the individuals' perceived capacity to obtain goals, emerged as the most significant predictor of subjective life satisfaction. The multidimensional concept of perceived social support which comprises four types of support was found to be a stronger predictor of subjective life satisfaction than the multidimensional concept of hope.

The most consistent correlate of perceived social support was the hope *state agency* subscale. Other findings were that the co-habiting and the married groups perceived that they have significantly more *tangible* and *affectionate* support when they needed it than singles. Cohabitees' also reported significantly more perceived *global* support than singles. Principal Components Analysis of the MOS-SS which was used to assess perceived social support and participants' responses on the dispositional and situational hope measures supported the theoretical frameworks the questionnaires were based on.

4.6 General Discussion

The current research sheds some light on how positive psychology research can help us to understand the processes that lead to positive experience and life satisfaction. Future studies focusing upon how happy people who are satisfied with their lives function, might give us useful insights regarding how to protect very unhappy people against psychopathology. For example, having thoughts about being capable of attaining goals (*agency*), emerged in the current study as the most significant predictor of subjective life satisfaction. Therefore, the *agency* component of hope theory could be protecting us against psychopathology by cultivating subjective life satisfaction. Longitudinal or prospective studies could be designed to assess this.

Global social support is a term which describes all four of the assessed dimensions of social support. When entered into the linear regression analysis as a factor it accounted for more of the variance in subjective life satisfaction than *global trait* and *global state* hope. Sarason, Shearin, Pierce, & Sarason (1987) argue that a supportive relationship involves communication of acceptance and love. The main effect of this feeling that we are loved and valued and that our well-being is of concern to significant others, is not to protect us from possible harm. According to Sarason et al. the primary outcome of this feeling is instead to help us to perceive that we are worthwhile, capable and valued members of a group. It also helps us to recognise that the resources needed for us to pursue our

goals are available either within ourselves, or through a combination of our own efforts and those of significant others.

Examination of group differences provided support for the idea that close relationships could positively influence perceptions of the availability of social support. Specifically, the results suggested that the co-habiting and the married groups perceived that they have significantly more *tangible* and *affectionate support* when they needed it than singles. Cohabitees also reported significantly more overall support than the singles did. These findings are broadly consistent with previous research conducted by Sherbourne & Hays (1990), which highlighted the importance of marital status in perceptions of social support availability.

Most of the variance in subjective life satisfaction was accounted for by *Agency state*, that is, one possessing a situational as opposed to a dispositional cognitive style which leads to goal directed determination. This result is consistent with findings by Bailey et al. (2007) who in two different studies also found *agency* to predict subjective life satisfaction. The present study also provided similar findings to Bailey et als' study as it confirmed that *agency* cognitions lead to greater subjective life satisfaction than believing in one's own capacity to generate plans that will foster goal attainment *(pathways cognitions)*. Therefore, results from both studies point to the idea that *agency* cognitions are sufficient to predict

subjective life satisfaction, independently of the experience of *pathways* cognitions.

In his theory of eudemonia, Aristotle argues that we flourish by living in a way that enables us to reach our full potential and by doing so we are capable of displaying the best self we can. By keeping people motivated to initiate and sustain action towards goals; hope and *agency* cognitions in particular, could drive us to pursue happiness by experiencing more fulfilling, meaningful and satisfying lives. *Agentic* thinking could therefore be a positive psychological virtue that if cultivated might strengthen perceptions of life satisfaction and lead us to evaluate our lives more positively.

The current research also points to the direction of researching family life and social relationships in order to understand subjective life satisfaction. Specifically, the data obtained indicates that the more one perceives they have someone to provide them with support, the higher his/her subjective life satisfaction is. Despite several social scientists having argued that social support is not directly related to subjective well-being (e.g. Pahl 2003; Diener & Fujita, 1995); Peterson (2006) argues that it is a consistent finding in Positive Psychology that social relationships matter greatly in explaining a satisfied life. For example, it has been shown that happiness and well-being depends on having meaningful social relationships (Diener & Seligman, 2002). Froth et al. (2007) found that interpersonal relationships predict subjective life satisfaction. Diener & Oishi

(2000) found that students who value money more than love are dissatisfied with their lives. The strength of the correlations obtained in the current study between various types of perceived social support and subjective life satisfaction, suggest that some types of support may influence the way in which people evaluate their lives more than others. Specifically, there were stronger correlations between subjective life satisfaction and *affectionate* and *emotional* support than with *positive social interaction* and *tangible* support.

Cross-cultural differences could influence the factors implicated in predicting subjective life satisfaction. Peterson, et al. (2007) found that *gratitude* was the most robust predictor of life satisfaction in a US sample whilst *perseverance* was the strongest prediction of life satisfaction in a Swiss sample. These findings suggest that life satisfaction in a certain country may evolve as a consequence of living in accordance with the strengths valued within that nation.

Several other variables which may positively affect our subjective life satisfaction, such as *gratitude* could have been considered in this study. Emmons (2007) argues that *gratitude* is a positive emotion or attitude in acknowledgment of a benefit that one has received or will receive. It would be of interest to investigate whether hope and perceived social support are associated with gratitude. With regards to hope, one hypothesis is that goal-directed determination (*agency*) will lead to increased gratitude and subjective life satisfaction by fostering the perception that desirable goals can be met.

Tesser, Gatewood, & Driver, (1968) found that individuals are more likely to experience gratitude when they receive a favour that is perceived to be valued by the recipient. It would therefore be useful to investigate whether perceived social support leads to gratitude by fostering perceptions that necessary resources are available when needed in order to obtain desirable goals. Another research idea would be to assess whether those who perceive that support is available to them when they need it are more likely to *persevere* in attaining desirable goals and by doing so increase their hopefulness, gratitude and subjective life satisfaction.

Although these research questions provide avenues for further research into subjective life satisfaction, it was decided in the current study to focus upon the factors hope and perceived social support. This is because these constructs originate from more clearly defined models and there is more evidence to suggest that these variables have a positive impact on our mental health.

The present study provides preliminary information about the relationships between hope, social support and subjective life satisfaction. The relatively large sample size allowed sophisticated statistical techniques, such as factor and linear regression analyses to be conducted and the results to be interpreted with confidence. In addition, the number of participants obtained decreases the risk of Type II errors associated with small sample sizes. It is important to acknowledge that due to the cross-sectional nature of the design it is not possible to infer

causality between the study variables. Future longitudinal studies are required to clarify the direction of the relationships between the variables.

The study encountered several methodological limitations. Firstly, as mentioned earlier in the discussion there is a sampling bias as participants were primarily Caucasian females. This affects the external validity of the study and limits us from being able to generalize the findings to a wider population. It was not possible to recruit ethnic and marital groups of equal size. As there were only a small number of participants in groups other than *Caucasian,* it was not possible to test for differences between ethnic groups.

Statistical tests for differences were carried out for participants across different marital status groups (with the exception of the *separated/divorced* group which was excluded from the analysis because it had an insufficient number of participants). The groups were of an unequal size, which is known to interfere with statistical analysis (Tabachnik & Fidell, 2001). Equal sized groups could have provided a more robust result. This said, testing for ethnic and marital status group differences were not the primary concerns of the study.

The measurement of social support is a complex task burdened with methodological difficulties (see Hutchison, 1999; Hupcey, 1998). When designing the study it was decided to assess social support using the Medical Outcomes Study Social Support Survey (MOS-SS) mainly for two reasons. The first was

because the instrument is designed to allow assessment of the multidimensional nature of social support. It measures various types of support. The second was because the MOS-SS assesses respondents' subjective judgments about the amount of social support they consider is available to them, instead of measuring actual support received. This decision was made because there is increasing recognition amongst researchers that perceived social support can be more predictive of well-being than the actual support received (e.g. Sarason, et al. 1991).

A disadvantage of measuring perceived rather than actual social support could be that respondents may exhibit a self-presentational bias that could predispose them to either over or under estimate the degree to which social support is available to them when they need it. Respondents may also over-estimate their levels of potential support availability due to the effects of social desirability. Nonetheless, measures of actual social support have been found to be no less problematic (see Hupcey, 1998; Hutchinson, 1999). In their favour, measures of perceived social support are the most person-centred and practical means of assessing support. There is research evidence which suggest that perceived social support, but not received support, is more strongly related to life satisfaction (Kazarian & McCabe 1991).

Due to a lack of valid and reliable measures to assess social support it was particularly important to examine if the MOS-SS would show an appropriate level

of reliability-internal consistency. In order to examine this, data analyses using Cronbach's alpha were performed, which suggested that all subscales of the MOS-SS demonstrated good internal consistency. It was also encouraging to observe that factor analytic evidence obtained through examination of the items of the MOS-SS, suggested that the construct validity of this measure is high. The exception to this was item seventeen, for which both meanings of *emotional/informational support* and *positive social interaction* can be attached. It is possible that item seventeen is a link between the two factors.

Further support for the validity of the MOS-SS came from an additional principal components analysis, which was conducted to account for the dimensions of *trait* and *state hope* and for the four dimensions of social support. The results obtained were as might be expected. The principal components analyses showed that all four dimensions of the MOS-SS measure the same construct. The four dimensions of social support loaded together on one factor, which was labelled *global social support.* Overall the results supported the idea that social support is a multidimensional concept that needs to be distinguished into several dimensions before meaningful assessment of the concept can be made. The findings obtained from the two factor analyses conducted, strongly validated the utility of the MOS-SS in measuring the multidimensional nature of social support.

As the study utilised a cross-sectional design, it was not possible to address causal relationships between hope, different types of social support and subjective life

satisfaction. A prospective or longitudinal study would enable us to examine causal relationships between the study variables with more confidence. However, due to time and resource constraints this was beyond the scope of this study. Qualitative studies may also be useful in helping us to identify factors that people associate with life satisfaction and happiness.

Despite its limitations, the study makes a new contribution to the area of subjective life satisfaction and positive psychology and has implications for clinical practice. Perceived social support may be a fruitful area for further research aiming to examine subjective life-satisfaction. Hope and in particular *agency* (goal directed determination) could provide a useful focus for clinicians who aim to develop interventions promoting subjective well-being.

4.7. Implications of positive psychological research for counselling psychology

In order to have confidence that the findings of the present study could have implications for clinical practice, it would be necessary to assess the variables using prospective studies. This said, the study replicated the result obtained by previous research (Bailey, et al. 2007) that *agency*, a term which refers to having thoughts about goal-directed determination, accounted for most of the variance in subjective-life satisfaction.

Seligman and Csikszentmihalyi (2000) argue that an aspect of applied positive psychology is the study and practice of therapeutic techniques based on cognitive-

behavioral therapy. These techniques are aimed at assisting clients in developing an increased awareness of their own positive character strengths, emotional processing and belief systems. They could be utilised to assist clients to take their focus away from their problems and direct it towards their strengths. Such strategies aim to empower individuals to take control of their lives, to increase their capacity for effective decision-making and to persist in pursuing goal-directed activities. By cultivating what is best within themselves clients live more meaningful and fulfilling lives.

On the surface, positive techniques may seem similar to ideas of solution-focused therapy. Solution focused therapy attempts to shift a client's focus away from the problem to the solution through the utilisation of various strategies such as the miracle question (De Shazer, 1985). The miracle question is a method of questioning that a therapist uses to aid the client to envision how the future will be different when the problem is no longer present. The aim is to shift the client's focus from what they could not do, to what they could do. They are encouraged to focus on their strengths rather than their weaknesses. Through this process clients feel more empowered, self confident and in control of their lives by shifting their focus from problems to solutions.

One fundamental difference between positive psychological techniques and solution focused therapy is the scientific basis that underpins positive psychology. In the future it is anticipated that positive techniques will complement effective

pre-existing approaches such as cognitive behavioural therapy and solution focused therapy. It is hoped that positive techniques will promote happiness through the discovery and implementation of evidence-based strategies which will be derived from psychological research and theory. We would be able to scientifically scrutinise such methods and as such we could arrive at a position where we would know what works and why. By doing so we could promote effective clinical practice. For example, Seligman, Steen, Park and Peterson (2005) found that two happiness interventions made people happier (and less depressed) up to six months later. The first was writing about three good things that happened each day and why they happened. For the second intervention, during assessment clients identified what they felt was their main character strength. They applied this main character strength in new ways every day. For example, someone who feels their main strength is courage and is agoraphobic could apply this courage in exposing themselves to different situations that he/she fears.

Principles of positive psychology could help people to cope effectively with adversities that occur in their lives. For example, *agency* (a person's goal-directed thinking which incorporates the affirmative thought "I can,") was found by this study to be the strongest predictor of subjective life satisfaction. Interventions could therefore be developed aimed at strengthening clients' goal-directed determination in order to help them evaluate their lives more positively. Our

knowledge of the factors that can foster beliefs which could lead people to increase their happiness and positive life experience, could be enhanced by further research in positive psychology. Future research could focus upon examining how goal-directed thinking (*agency*) increases subjective-life satisfaction. We can theorise that this occurs for various reasons such as:

- It empowers individuals by leading them to perceive they have control over their lives.
- It leads individuals to pursue goal directed activities.
- By having the character strength to focus on goal-directed determination hopeful individuals may attain desirable goals. By doing so they may evaluate their lives positively, by gaining purpose, meaning and life satisfaction.

Moreover, *global* perceived social support accounted for more variance in subjective life satisfaction than *global* hope. This result suggests that clients who are dissatisfied with their lives and those who aspire to increase their life satisfaction, might benefit from interventions aimed at strengthening their perception that necessary resources are available to them when they need them. Specifically, identifying the areas in which clients perceive they lack the resources necessary to pursue valued goals and working with them towards facilitating perceptions of support availability, may lead clients to evaluate their lives more positively.

Since perceived social support is a multidimensional concept, it is necessary for clinicians to work with their clients to identify the specific areas of support they perceive they are lacking. For example, one person may perceive they are lacking in emotional support and another in tangible support. Some clients may perceive they lack support in more than one domain. It is important that clinicians assess their clients' perceived support availability across the different support domains namely, *emotional/informational support*, *tangible support*, *positive social interaction* and *affectionate support.*

By identifying their clients' needs through a problem-solving or solution focused approach, clinicians can facilitate them to consider options that could help them to strengthen their perceptions of support availability. For example, a person who perceives they are lacking in positive social interaction could be encouraged to join a social club. In order to strengthen perceptions of support availability, clients could be asked to keep a diary of the support they feel they receive each day. Another strategy might be to identify clients' best character strengths and facilitate them to apply these strengths in ways that they can foster perceptions of support availability.

Examinations of group differences between the co-habiting, married and single groups, point to the idea that close relationships promote subjective life satisfaction. Floyd & Morman (2005) argue that satisfaction, development and maintenance of personal relationships are often gauged through the expression of

affectionate communication. Research has shown that affectionate communication is significantly associated with closeness and satisfaction in married couples (Bell, Daly & Gonzales, 1987) and sibling relationships (Rittenour, Myers, Brann 2007). Froth et al. (2007) found that interpersonal relationships predict subjective life satisfaction.

In order to assist clients in initiating and maintaining reliable close relationships, Counselling psychologists could develop interventions aimed at increasing their clients' awareness of the importance of conveying feelings of fondness, support and love to those important to them. Facilitating clients to develop and maintain an affectionate communication style could enhance their life satisfaction through the maintenance of close personal relationships, which could subsequently strengthen their perceptions of support availability. There is research to suggest that close social relationships are essential to well-being. Lucas, Clark, Georgellis and Diener, (2003) conducted research on widows and discovered that they experienced significant reductions in well-being right before and after the loss of a significant other. Diener & Seligman, (2002) found that the happiest individuals reported having strong positive social relationships.

The field of positive psychology can further contribute to our knowledge of positive mental health and enhance our clinical practice through scientifically assessing the conditions and processes that contribute to the flourishing and optimal functioning of people, groups, and institutions. Within a positive

psychology perspective the counselling psychologist's role is to identify and nurture their clients' strengths in order to help them enhance their quality of life, well-being and life experiences. The clinician conducts the session attempting to cultivate their clients' strengths, to help them to foster their finest qualities in order to help them lead more meaningful, satisfying and fulfilling lives.

As positive psychology is still in its infancy it is hoped that interventions based on research findings could provide the way to help us increase our life satisfaction and well-being. Research aimed at examining which factors lead to fulfillment, positive life experience and life satisfaction is essential for the clinical practitioner. As Froh et al. (2007) point out, in our daily practice aiming simply to decrease symptoms of negative states such as anxiety and depression, does not necessarily guarantee an improvement in our clients' quality of life and well-being.

5.0 Conclusions

This research has shed some light on the potential influence of hope and perceived social support on subjective life satisfaction. The results point to the idea that the *agency* component of hope theory is sufficient to predict subjective life satisfaction, independently of the existence of *pathways* cognitions. Global perceived social support was found to account for more of the variance in subjective life satisfaction than global hope. Longitudinal studies however are still needed to clarify causal relationships between the variables.

This study had a positive impact on the researcher's professional practice. It enabled him to pay more attention to recognize his patients' strengths instead of focusing exclusively to "repair" their weaknesses. The researcher increased his awareness of the importance to focus on encouraging his clients to cultivate what is best within themselves and to apply their strengths in constructive ways in order to facilitate them to attain their valued goals.

The advanced case study and process report which are documented in later sections of this portfolio highlight that the utilization of evidenced based techniques can enable our clients to increase their hope and well being. Through accomplishing valued goals which they perceived as being unmanageable before entering therapy, clients strengthen their Agentic thinking. This means that they begin to perceive that they are capable of achieving the goals that they set for themselves. This perception in turn, leads clients to become filled with the anticipation that they can achieve future successes. The belief that future goals are attainable could lead them to evaluate their lives more positively. As positive psychology research continues to expand, future research will determine other factors which positively influence our subjective life satisfaction.

6.0 References

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8.0 Appendices

Appendix 1 Participant Information Sheet

The role of hope and social support in subjective life satisfaction

My name is Stavros Markatselis and I am completing my training to be a Counselling Psychologist. As part of the academic requirement of the Professional Doctoral Programme in Counselling Psychology at City University, I am required to conduct a research project. I have chosen to research whether hope and social support, two concepts that are considered to help us cope with adversity, also influence our life satisfaction. I hope that this study will help professionals to understand more the ways in which positive

concepts help us to increase our well-being, so that we can develop methods to cultivate them in order to feel happier and more satisfied with our lives. I am therefore asking whether you would be interested in participating in my study. Before you decide, it is essential that you understand what the research is about and what you will need to do. Please take time to read the below information. Please do not hesitate to ask me if you have any questions regarding the research.

The aims of the study.

The study aims to contribute to the field of positive psychology. This field is relatively new and is dedicated to researching positive constructs. Through understanding the ways in which positive concepts influence our well-being, it is hoped that we would be able to cultivate what is best within ourselves so that we can enhance our life experiences and life satisfaction.

Who is suitable to take part?

For the study to be meaningful as many people over 18 as possible are being approached.

Your participation is voluntary

It is up to you to decide whether you would like to take part. Deciding not to take part will have no impact on you whatsoever.

What will I have to do if I decide to take part?

People who agree to participate are requested to fill in a questionnaire, which will take them less than ten minutes to complete. If you agree to take part you will be given 3 anonymous questionnaires (1 each about hope, social support and life satisfaction) and a brief anonymous questionnaire about yourself. If you wish to take the questionnaires with you to complete them at a place of your choice, a FREEPOST envelope will be provided for the questionnaires to be returned by post. If you are completing them online, using the internet, once you complete the questionnaires your answers will be sent automatically to me through the website.

Completing the questionnaires online will be taken as evidence of you giving informed consent for your answers to be used in this study. This step is taken to ensure your anonymity and therefore you do not have to provide your name.

Appendix 2

Statement of Consent

I understand that I may withdraw my consent and discontinue participation at any time without penalty or loss of benefit to myself. I understand that data collected as part of this research project will be treated confidentially, and that published results of this research project will maintain my confidentially. In signing this consent letter, I am not waiving my legal claims, rights, or remedies. A copy of this consent letter will be offered to me.

(Circle Yes or No)

I give consent to participate in the above study.

Yes No

Date:

If you have any questions regarding this study please contact:

Stavros Markatselis, Counselling Psychologist in Training

E-mail: [redacted]

Telephone: [redacted]

This research is approved as being ethical by the Department of Psychology Research Ethics Committee at City University. All information will be collected anonymously and will be kept strictly confidential. The data will be stored anonymously in a non-networked, password protected computer. Paper questionnaires will be kept securely locked in a cabinet.

Appendix 3

Debriefing Statement

The aim of this research was to investigate the role of hope and social support in helping us be more satisfied with our lives. The research did not use deception. If you have any further questions please contact me Stavros Markatselis at email: [redacted] or telephone: [redacted].

If you have questions about your rights as a participant in this research, or if you feel that

you have been placed at risk, you may write to Dr Don Rawson, School of Social Sciences, Department of Psychology, City University, London, EC1V 0HB.

The study did not include any questionnaires that are designed to be distressing. However if you found it distressing answering any of the questions and feel that you would like to speak to someone about it, please find below a few resources whom you can contact:

- **MIND INFOLINE** - Support for anyone worried about their own or others' mental health problems. Telephone: 08457 660 163
  (open Monday to Friday 9.15am to 5.15pm)
  Textphone: For deaf or speech impaired enquirers 0845 330 1585 If you are using BT Textdirect add the prefix 18001 (open Monday to Friday 9.15am to 5.15pm)
  Mind - The Mental Health Charity, 15 - 19 Broadway, Stratford, London E15 4BQ

  Email: info@mind.org.uk

  Website: http://www.mind.org.uk

- **SANELINE** 0845 767 8000 (12noon to 2am)
  Telephone helpline offering practical information, crisis care and emotional support to anybody affected by mental health problems.

Appendix 4

The Adult Trait Hope Scale

(Snyder et al. 2006)

Directions

Read each item carefully. Using the scale shown below, please select the number that best describes YOU and put that number in the blank provided.

1 _ Definitely false

2 _ Mostly false

3 _ Somewhat false

4 _ Slightly false

5 _ Slightly true

6 _ Somewhat true

7 _ Mostly true

8 _ Definitely true

1. I can think of many ways to get out of a jam.

2. I energetically pursue my goals.

3. I feel tired most of the time.

4. There are lots of ways around any problem.

5. I am easily downed in an argument.

6. I can think of many ways to get the things in life that are important to me.

7. I worry about my health.

8. Even when others get discouraged, I know I can find a way to solve the problem.

9. My past experiences have prepared me well for my future.

10. I have been pretty successful in life.

11. I usually find myself worrying about something.

12. I meet the goals that I set for myself.

Appendix 5

The Adult State Hope Scale

(Snyder et al. 2006)

Directions

Read each item carefully. Using the scale shown below, please select the number that best describes *how you think about yourself right now* and put that number in the blank

before each sentence. Please take a few moments to focus on yourself and what is going on in *your life at this moment.* Once you have

this "here and now" set, go ahead and answer each item according to the following scale:

1 _ Definitely false
2 _ Mostly false
3 _ Somewhat false
4 _ Slightly false
5 _ Slightly true
6 _ Somewhat true
7 _ Mostly true
8 _ Definitely true

___1. If I should find myself in a jam, I could think of many ways to get out of it.

___2. At the present time, I am energetically pursuing my goals.

___3. There are lots of ways around any problem that I am facing now.

___4. Right now, I see myself as being pretty successful.

___5. I can think of many ways to reach my current goals.

___6. At this time, I am meeting the goals that I have set for myself.

Appendix 6

The Satisfaction With Life Scale

(Diener, Emmons, Larsen & Griffin, 1985).

Directions:

Below are five statements with which you may agree or disagree. Using

the 1-7 scale below, indicate your agreement with each item by placing the appropriate number in the line preceding that item. Please be open and honest in your responding.

1 = Strongly Disagree

2 = Disagree

3 = Slightly Disagree

4 = Neither Agree or Disagree

5 = Slightly Agree

6 = Agree

7 = Strongly Agree

_____1. In most ways my life is close to my ideal.

_____2. The conditions of my life are excellent.

_____3. I am satisfied with life.

_____4. So far I have gotten the important things I want in life.

_____5. If I could live my life over, I would change almost nothing.

Appendix 7

Medical Outcomes Study Social Support Survey (MOS-SS)

(Sherbourne & Stewart 1991)

People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it? Put in **BOLD** one number on each line.

	None of the time	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**

Someone you can count on to listen to you when you need to talk	1	2	3	4	5
Someone to give you information to help you understand a situation	1	2	3	4	5
Someone to give you good advice about a crisis	1	2	3	4	5
Someone to confide in or talk to about yourself or your problems	1	2	3	4	5
Someone whose advice you really want	1	2	3	4	5
Someone to share your most private worries and fears with	1	2	3	4	5
Someone to turn to for suggestions about how to deal with a personal problem	1	2	3	4	5
Someone who understands your problems	1	2	3	4	5
Someone to help you if you were confined to bed	1	2	3	4	5
Someone to take you to the doctor if you needed it.	1	2	3	4	5
Someone to prepare your meals if you were unable to do it yourself	1	2	3	4	5
Someone to help with daily chores if you were unwell	1	2	3	4	5
Someone who shows you love and affection	1	2	3	4	5
Someone to love you and make you feel wanted	1	2	3	4	5
Someone who hugs you	1	2	3	4	5
Someone to have a good time with	1	2	3	4	5
Someone to get together with for relaxation	1	2	3	4	5
Someone to do something enjoyable with	1	2	3	4	5
Someone to do things with to help you get your mind off things	1	2	3	4	5

Appendix 8

Demographic Questionnaire

1. Are you

Male or Female **(please circle)**

2. Please indicate your age _____

3. Your Ethnic Origin (please circle)

Black/African American

Asian

White/Caucasian

Hispanic

Other

Prefer not to answer

4. Please type your occupation (e.g. student)

_____

5. Your Marital Status (please circle)

Separated/Divorced

Widowed

Co-habiting

Single

Married

CASEWORK

CITY UNIVERSITY, LONDON

School of Social Sciences, Department of Psychology

Advanced, Specialist Client Study

Cognitive-behavioural treatment of a 36-year old woman with depression.

In order to protect confidentiality the name of the client has been disguised in this case study.

The Professional Practice Component of this thesis has been removed for confidentiality purposes.

It can be consulted by Psychology researchers on application at the Library of City, University of London.